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# JOURNAL

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JANUARY

1999

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Stereotactic Breast Biopsy: Experience in a Community Setting

Outpatient Diabetes Management of Medicare Beneficiaries in Four  
Mississippi Fee-for-Service Primary Care Clinics

## SPECIAL ARTICLE

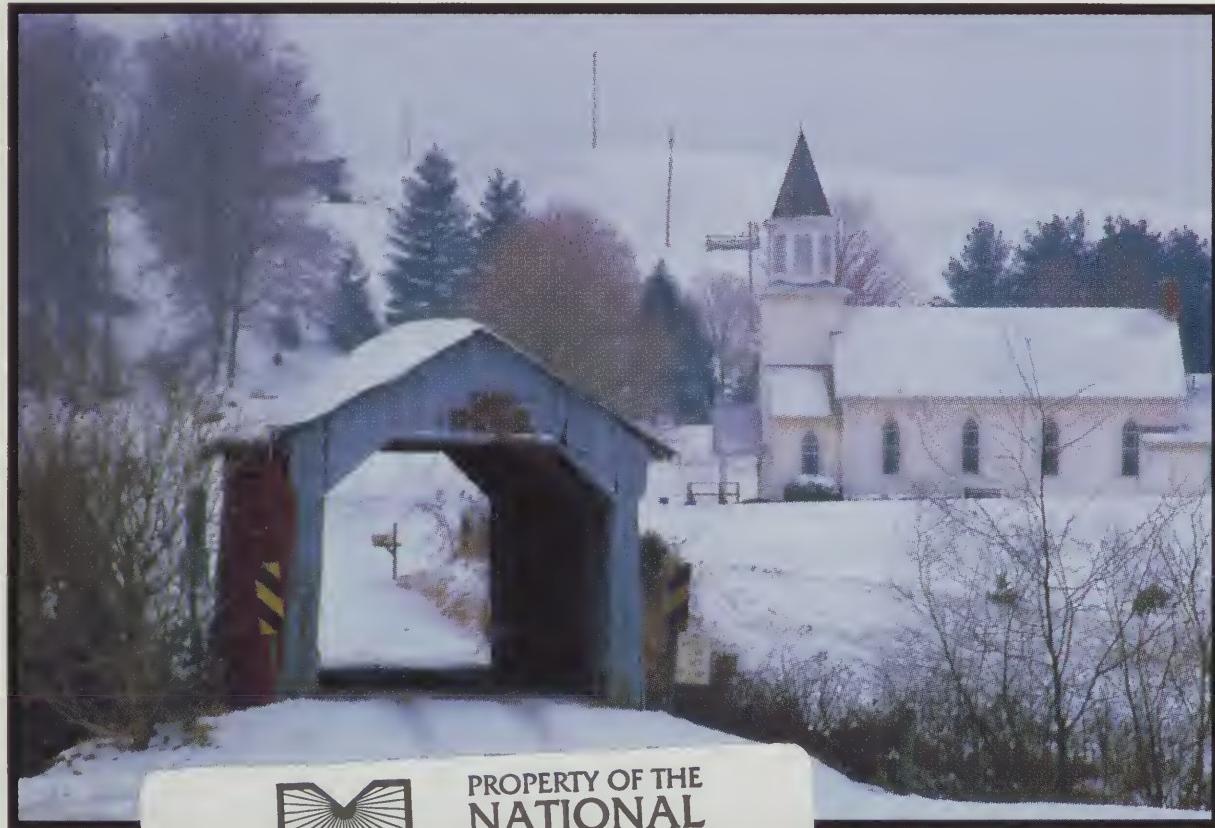
Coding Concepts

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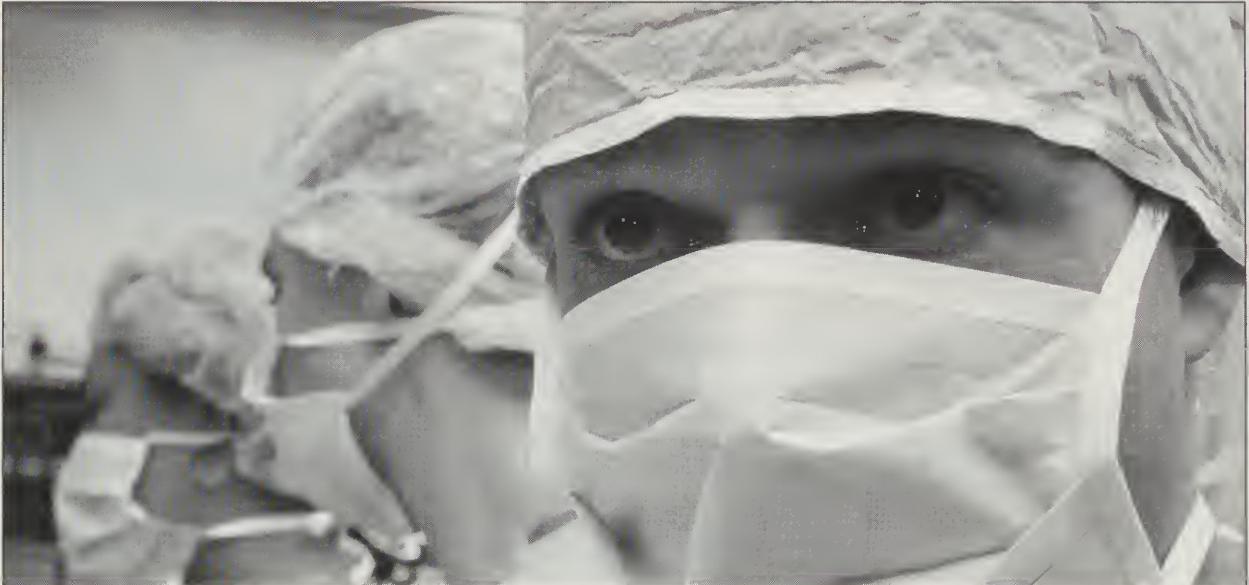
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## EDITORIAL

Thomas Jefferson's Y Chromosome: The Power and Limitations of DNA Analysis



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# Stereotactic Breast Biopsy: Experience in a Community Setting

Ronald E. Gray, M.D.  
Gary W. Benson, M.D.  
Donna D. Lustig, R.T. (R)(M)

## A BSTRACT:

This article reviews the first year experience with stereotactically guided percutaneous breast biopsy at Baptist Health Systems Women's Center. One hundred forty eight procedures were performed on one hundred forty one patients from July 1997 through July 1998.

Our biopsy program is a cooperative effort involving surgeons, radiologists, pathologists, and ancillary health care personnel. In accordance with published literature, we have found the procedure to be efficacious, safe, cost effective and well accepted by patients and physicians. The advantages and limitations of minimally invasive breast biopsy are discussed as well as our concept of the role of this technique in management of patients with an abnormal mammogram.

### Key Words: Breast Biopsy, Minimally Invasive, Stereotactic Guidance

The 1990's have seen image guided large core needle biopsy become well accepted in the management of nonpalpable mammographic lesions.<sup>1</sup> In our practice, ultrasound guided core biopsy of solid nodules has become commonly utilized, due to its accuracy, low morbidity and low cost. Our experience has paralleled that of the published literature in that we have seen a significant

decrease in the number of needle localized, surgical biopsies for benign disease.<sup>2</sup> The primary limitation of ultrasound, however, is that many mammographic abnormalities such as small nodules, asymmetric densities, or microcalcifications could not be sampled with this technique.

Ultrasound guided core needle biopsy of solid nodules remains an important part of our practice. Some mammographic findings, such as microcalcifications, present a more complex diagnostic challenge, however. It is known that within an individual lesion there may be coexisting foci of atypical hyperplasia and carcinoma.<sup>3,4</sup> In light of this, and the relatively small sample size obtained with the 14g. core needle<sup>3</sup> we were reluctant to embrace core needle biopsy of microcalcifications in our practice. The availability of the 11 gauge directional, vacuum assisted, biopsy probe (Mammotome, Biopsys Inc., Irvine, CA) has addressed this concern. The much larger specimen obtained by the 11g Mammotome unit, (approximately 95 mg. as opposed to 18 mg with the 14g needle<sup>5</sup>) and the total specimen weight of up to 1500 mg. per Mammotome biopsy case<sup>6</sup> greatly reduces the possibility of sampling error. Indeed, preliminary published work indicates that underestimation of pathology when using the 11 gauge

biopsy probe is unlikely<sup>7</sup>, especially when the entire lesion is removed. The Mammotome device not only yields a much larger specimen than the 14 gauge core needle, but also enables the deployment of a surgical marker clip (Micro Mark Clip, Biopsys Inc., Irvine Ca.). With the Mammotome device, small areas of calcification or small densities are frequently totally excised. The marker is employed to identify the site of biopsy on future mammograms and also to serve as a target for localization should surgical excision be required.

Image guided minimally invasive biopsy has many advantages over open surgical biopsy. In parallel with the published literature,<sup>1,3,& 8</sup> we have found this procedure to combine a high degree of diagnostic accuracy with a significant cost savings, low patient morbidity, and a high degree of acceptance by patients and referring surgeons. Published literature,<sup>3,8</sup> indicates an anticipated cost saving of 50% for minimally invasive over traditional needle localization and surgical excision; our experience has shown a similar reduction. Compared to traditional surgical biopsy, post surgical changes and architectural distortion on follow up mammograms are minimized.<sup>9</sup>

As with any procedure, there are limitations.<sup>3 & 10</sup> Depending on the location within the breast, the lesion may not be accessible to the stereotactically guided biopsy instrument. Lesions far posterior, near the chest wall or in a very superficial location are the most obvious examples. A cooperative patient is an absolute requirement. Patients who are unable to lie prone and still for the twenty to thirty minute duration of the procedure are not acceptable candidates. The radiologist performing the procedure must ensure that the histologic results from the image guided biopsy are in accordance with the radiologic diagnosis. Otherwise, the possibility of a missed lesion exists.<sup>11,12</sup> Percutaneous biopsies yielding malignant diagnoses, high risk lesions such as atypical ductal hyperplasia, or cases where the histologic diagnosis is at variance with the radiologic diagnosis, must be considered for surgical excision.

## EQUIPMENT:

All biopsies in this series were performed at the Baptist Women's Center using a dedicated stereotactic biopsy unit (Mammotest, Fischer Imaging, Denver CO.). In light of the limitations of 14 gauge core needle biopsy for some lesions, all biopsies were performed using the 11 gauge Mammotome device.

## PATIENT SELECTION AND MANAGEMENT:

Lesions that are visible by ultrasound are by pref-

erence biopsied with a large core needle under ultrasound guidance. Most lesions referred for stereotactic biopsy are either suspicious calcifications or small focal densities, not visible by ultrasound.

Stereotactically guided biopsies are performed at the Women's Center by surgical referral. These procedures are performed by a group of radiologists with a particular interest in image guided breast biopsy.

Biopsies are scheduled at the patient's convenience. Prior to scheduling, the patient is interviewed by the radiologic technologist, medical history is obtained and a procedure information sheet is given to the patient.

Films are reviewed by the radiologic technologist and the radiologist prior to scheduling, in order to screen out inaccessible lesions or obviously benign findings (such as dermal calcifications) that may not require biopsy. In some cases, when the radiographic findings are questionable, additional radiographic views are obtained prior to proceeding with biopsy. Pertinent items in the medical history include anticoagulant therapy, bleeding disorder, drug allergy, as well as any history of heart failure, respiratory disease, arthritis or mental disorders that may make the patient unable to cooperate fully.

The details of the procedure are well documented in the literature<sup>6</sup> and will only be summarized here. The patient is placed in the prone position on the stereotactic table and preliminary localizing images are obtained. Following skin preparation and local anesthesia, the biopsy instrument is advanced to the predetermined coordinates. Post placement stereotactic images are obtained. Provided the probe is in satisfactory position, multiple tissue samples are obtained. Post biopsy stereotactic images are obtained to evaluate the adequacy of excision. If the lesion has been totally excised, a marker clip is left in place, as noted above. In the case of microcalcifications, specimen radiography is obtained to document the presence of the targeted calcifications within the specimen. The specimen radiograph is retained in the patients film folder and a duplicate radiograph is submitted along with the specimen for review by the pathologist.

Following the procedure, a post biopsy mammogram is obtained to document the presence of the clip, confirm adequacy of the biopsy, and serve as an initial post biopsy baseline.(Fig. 1)

Patients are contacted by their referring surgeons with the pathology report and arrangements are made for definitive therapy (in the case of malignant lesions) or follow up (in the case of benign lesions). For benign findings, a six month initial follow up mammogram is recommended to assess stability of the area of biopsy. As



Fig 1.—Left, Detail view of mammogram shows cluster of microcalcifications (arrow). Vascular and secretory calcifications are also present. Right, Post biopsy mammogram shows air within the tissues following biopsy. Targeted calcifications are removed and a surgical clip marks the biopsy site. *Histologic diagnosis: Fibroadenoma with microcalcifications.*

noted above<sup>9</sup>, mammographic changes resulting from the biopsy alone are minimal except for the placement of the clip.

On the day following the biopsy, the patients are evaluated by the Women's Center staff either in person or by telephone depending on patient preference. A post procedure satisfaction survey is sent to the patient.(Table 1, page 6)

#### BAPTIST HEALTH SYSTEMS EXPERIENCE:

During the period from July 1997 through July 1998 total of one hundred forty eight mammographic lesions were biopsied in one hundred forty one patients (five patients had two lesions each, one patient had three lesions). Pathology results are summarized in Table 2, page 7.

Of patients with atypical ductal hyperplasia, none were upgraded to carcinoma on subsequent excisional biopsy; one patient with a diagnosis of ductal carcinoma in situ was upgraded to invasive ductal carcinoma. One patient with a stereotactic biopsy diagnosis of fibrocystic disease went to surgical biopsy because the targeted calcifications could not be accessed with the biopsy probe; she was found to have invasive ductal carcinoma.

Potential complications resulting from the biopsy procedure include infection and post biopsy bleeding resulting in hematoma.<sup>3,10</sup> Complications have been rare in our experience. We have had no infections. There have been three palpable hematomas following biopsy, none requiring surgical drainage.

Missed lesions and falsely negative biopsy results may also be considered "complications" of this procedure. Missed lesions are avoided by review of the

post biopsy mammogram and specimen radiograph by the radiologist at the time of the biopsy. We have had one lesion which was initially missed but recognized upon review of the post biopsy mammogram and successfully biopsied at the same sitting. We have had no cases of false negative biopsy results in this one year period.

#### SUMMARY

We have found stereotactically guided, minimally invasive breast biopsy to be an important addition to the management of patients with an abnormal mammogram, complimenting the role of ultrasound guided core needle biopsy for management of nonpalpable abnormalities. Many patients with benign lesions are spared the expense and discomfort of open surgical biopsy. Patients with malignant findings are able to have, in many cases, definitive surgical management with one operating room visit, eliminating the need for separate surgical procedures for diagnosis and therapy.

Correctly used, this technique represents a significant contribution to rational and cost effective management of nonpalpable mammographic abnormalities. Cooperation between specialties is needed, however, to integrate this procedure into the diagnostic workup appropriately, and to minimize the possibility of missed lesions and falsely negative diagnoses.

—Ed. Note: Table 1 and Table 2 are found on the following pages.

**Table One**  
**PATIENT SATISFACTION SURVEY**

**TOTAL SURVEYS DISTRIBUTED: 119**  
**TOTAL SURVEYS RETURNED: 54**

<b>QUESTION</b>	<b>RESPONSE</b>		<b>NOT RESPONDING</b>
	<b>YES</b>	<b>NO</b>	
1. Did you experience any adverse event following your biopsy ?	0	54	65
2. Was the biopsy painful ?	4	50	65
3. Was your biopsy a satisfactory experience overall ?	53	1	65
4. Did the information you received prior to your biopsy answer your questions and prepare you for the procedure ?	53	1	65
5. If you have had a surgical breast biopsy, was this technique an improvement ?	17	1	101

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TABLE 2

BENIGN LESIONS	HIGH RISK LESIONS	MALIGNANT LESIONS
Fibrocystic Disease 72	* Lobular Neoplasia 2	Invasive Ductal Carcinoma 9
Fibroadenoma 36	Atypical Ductal Hyperplasia 3	Ductal Carcinoma In Situ 12
Intraductal Papilloma 2		Mixed Type 2
Papillomatosis 3		Colloid Carcinoma 1
Fat Necrosis 1		
Benign Breast Tissue 5 not otherwise specified		
<b>TOTAL</b>	<b>119 lesions</b>	<b>24 lesions</b>
	<b>5 lesions</b>	

\* formerly called lobular carcinoma in situ

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# Outpatient Diabetes Management of Medicare Beneficiaries in Four Mississippi Fee-for-Service Primary Care Clinics

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## A BSTRACT

### Background

As part of a quality improvement initiative aimed at increasing physician compliance with standards of care for diabetes patients, diabetes practice patterns among Medicare beneficiaries in four primary care clinics were examined in Mississippi.

### Methods

Retrospective chart reviews of Medicare beneficiaries with a diagnosis of diabetes were conducted to examine physician compliance with recommended diabetes monitoring services.

### Results

Fifty-three percent of all beneficiaries did not have a recorded A1c test while 54 percent did not have a recorded foot exam. The percentage without foot exams decreased with quarterly visits. Seventy-two percent and 68 percent of patients had testing for lipids and proteinuria, respectively, although variability in types of testing performed was seen. Seventy-six percent of beneficiaries did not have a referral for a dilated eye exam.

### Conclusions

The study has uncovered, within several primary

care sites in Mississippi, variable documentation of compliance with many clinically relevant recommendations relating to the care of elderly patients with diabetes. These items can be targeted for improvement as part of a statewide quality improvement initiative for Medicare beneficiaries.

**Key words:** Diabetes Mellitus, Medicare, Standards of Care, Primary Care

Several factors have come together in recent years that have made diabetes mellitus a priority for quality improvement initiatives.<sup>1-3</sup> One is the tremendous public health and economic burden of the disease in the U.S.<sup>4</sup> A second incentive has been evidence derived from clinical trials showing that complications can be prevented or limited by tight control of blood glucose levels and appropriate and timely interventions.<sup>5-9</sup> Practice recommendations, based on this data, have been published and are readily available.<sup>10</sup> Lastly, despite the existence of published clinical guidelines, it is now recognized that practitioner compliance with diabetes standards of care falls short of recommendations.<sup>11-15</sup>

Diabetes is one of the important diseases targeted for quality improvement by the Health Care Financing

Administration's Health Care Quality Improvement Program (HCQIP, 1-2). The prevalence of diabetes in the U.S. is highest among those  $\geq 65$  years of age, with diagnosed cases comprising 10-15 percent of the general Medicare population.<sup>15-16</sup> In addition, Medicare beneficiaries, as with other populations studied, have not received recommended monitoring services.<sup>13-15</sup> Projects to identify areas for improvement are initiated by individual state Peer Review Organizations (PROs), with the goal of developing interventions to improve the processes and outcomes of care.<sup>2</sup>

In Mississippi the rate of self-reported diabetes among those 65-74 years of age is 17 percent and exceeds that reported in any other state.<sup>17</sup> Data obtained through analysis of Medicare claims by the General Accounting Office (GAO) suggest that Mississippi ranks at the bottom for compliance with some indicators, such as eye examinations.<sup>15</sup> In order to develop interventions to improve the quality of diabetes care, additional baseline information was required on physician compliance with recommended monitoring services. Therefore, towards the long-term goal of modifying physician practice patterns and processes of diabetes care in the outpatient setting, Information & Quality Healthcare (IQH), the state PRO, examined physician diabetes practice patterns among Medicare beneficiaries in four Mississippi primary care clinics.

## METHODS

### Setting

Twenty-seven primary care physicians from four separate, fee-for-service clinics volunteered to participate in the study. The settings consisted of one solo practice, two small groups of six physicians each, and one large group of 14 physicians. Practice locations were one metropolitan, one rural, and two small cities. All physician participants belonged to primary care specialties (i.e., general internal medicine, family or general practice). These physician practices provide care for approximately five percent of all medicare beneficiaries with diabetes in the state.

### Case Selection and Data Collection

A list of beneficiaries with any diagnosis of diabetes (ICD-9-CM codes 250.00-250.93) was generated for each participating physician from the National Claims History Physician Supplier Medicare Part B database. All beneficiaries seen in the physician offices within a 12 month period between January 1, 1995, and December 31, 1995, were eligible for sample selection. Each

physician was asked to select 30 beneficiary charts from his/her list. The target sample size of 810 was calculated to give a total confidence interval width of 3-7 percent at a 95 percent confidence level. Charts were reviewed by trained abstractors of IQH. Patients who died, moved out of state, or received more than 60 days of care in a skilled nursing facility during the period of the study were removed from the sample. The final sample size was 709.

### Quality Indicators and Data Analysis

Eighteen months (6 quarters) of records were reviewed retrospectively on each patient for the following indicators: 1) number of visits with physician; 2) referrals for dilated fundoscopic exam; 3) performance of foot exams; 4) testing for urine protein and type of test performed; 5) hemoglobin A1c determination; 6) lipid testing and type of testing performed. The indicators were taken from the American Diabetes Association Clinical Practice Recommendations.<sup>10</sup> Data was entered into Epi Info, and exported to Microsoft Access (Microsoft Corporation) for analysis.<sup>18</sup>

## RESULTS

### Demographics of Beneficiaries

Records on 709 Medicare beneficiaries with diabetes seen by the primary physicians were reviewed. The median age of patients was 75 years (range 42-102 years). Seven percent were  $< 65$  years of age, 84 percent were between 65 and 84, and the remaining 9 percent were  $> 85$  years of age. A predominance of patients (62 percent) were female. Twenty-seven percent (192/709) of beneficiaries were African American, 72 percent (511/709) were Caucasian, and the remaining 1 percent (6/709) were members of other ethnic groups. These demographics are similar to the 1996 Medicare Enrollment data reported for Mississippi, with 61.5 percent female, and 25.8, 72.8, and 1.4 percent African American, Caucasian, and members of other ethnic groups respectively (1996 Medicare Enrollment Data, Health Care Financing Administration).

### Frequency of Visits

Information on number of beneficiaries seen by quarter is summarized in the Appendix Table. Sixty-nine percent (490/709) of patients were seen for at least 4 quarters over the 6 quarter review period. Six percent (45/709) of all beneficiaries had one quarterly visit with their physician, while a third (33 percent or 231/709) had 6 quarterly visits out of the 6 quarters reviewed (Figure 1).

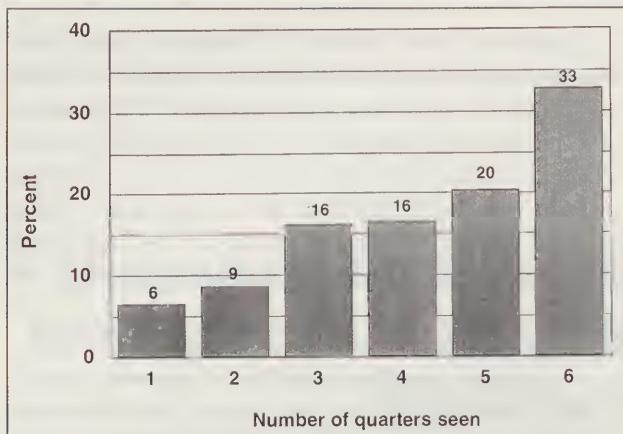


Fig 1.— Above, Percent of Medicare beneficiaries that had 1, 2, 3, 4, 5, or 6 quarterly visits to their primary care clinic.

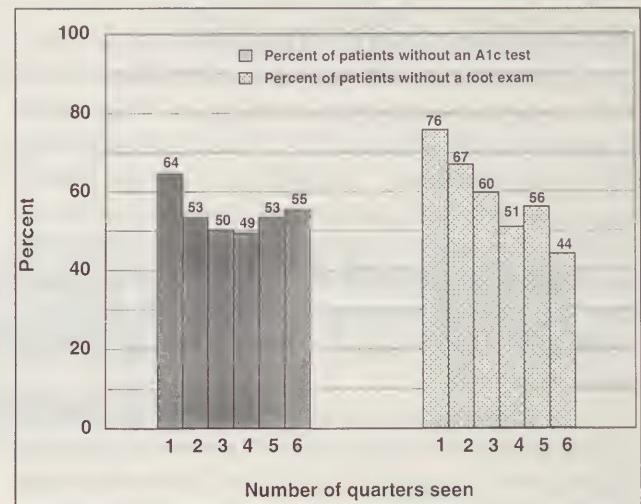


Fig 2.— Above, Percent of Medicare beneficiaries who did not have a hemoglobin A1c or recorded foot exam, by number of quarters seen.

## Hemoglobin A1c Testing, Foot Exams, and Dilated Eye Exams

A minimum of one A1c and one foot exam was expected per quarter seen. Fifty-three percent (379/709) and 54 percent (383/709) of all beneficiaries did not have a recorded A1c test or foot exam, respectively, during the 6 quarter review period (Appendix Table 1). The percent without an A1c varied by number of quarters seen, but was always near 50% or higher (Figure 2). There was no correlation between the percent without A1c measurements and number of quarters the patient was seen by the physician ( $r=-0.45$ ,  $p=0.37$ , Pearson's test for correlation). The percentage of patients without a foot exam decreased with more quarterly visits (Figure 2). A significant correlation was present between the percentage without foot exams and number of quarterly visits ( $r=-0.95$ ,  $p=0.004$ , Pearson test for correlation). Nonetheless, even 44 percent of those seen for 6 out of 6 quarters still did not have a foot exam (Figure 2). Seventy-six percent (550/709) of beneficiaries did not have a referral to a dilated eye exam during the period under review (data not shown). A small number of beneficiaries received an A1c test or foot exam for each quarterly visit, and a few even exceeded the expected frequency (Appendix Table).

## Lipid and Urine Protein Testing

For the period reviewed, 72 percent (510/709) of patients had some type of lipid screening performed. Thirty-two percent (223/709) had a full lipid profile (cholesterol, LDL-cholesterol, HDL cholesterol, and triglycerides), 11 percent (78/709) had

a cholesterol only, and 29 percent (209/709) had either an HDL, LDL, or triglyceride performed (Figure 3).

Documentation of testing for proteinuria was absent in 32 percent (226/709) of charts. For those who received proteinuria screening, sixty-two percent (439/709) had protein screened via routine urinalysis, 2 percent (12/709) had testing specifically for microalbuminuria, and 5 percent (32/709) had screening both by urinalysis and microalbumin testing. (Figure 3).

## DISCUSSION

As a result of a combination of the high prevalence and cost of disease, evidence demonstrating the

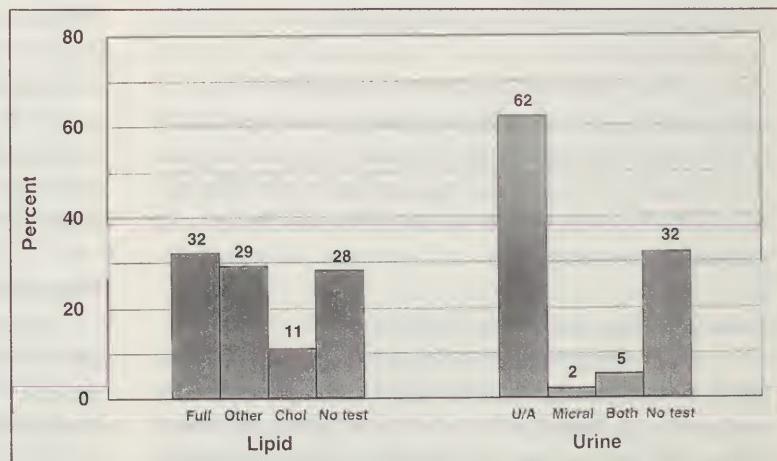


Fig 3.— Above, Percent of Medicare beneficiaries who received lipid and proteinuria screening, by type of test performed. Full = full lipid profile, Other = other testing, Chol = cholesterol only, U/A = urinalysis only, Micral = quantitative test for microalbumin, Both = U/A + Micral. No test = no testing documented.

benefit of specific preventive and interventional measures, the availability of practice guidelines, and data showing variable physician compliance with recommended monitoring services, raising the quality of diabetes care has now become a target of a number of quality improvement initiatives in the U.S.<sup>1-3</sup> Through its HCQIP and collaboration with state-based PROs, HCFA now has a focus on developing diabetes quality improvement programs in the Medicare population.<sup>1-3</sup> In Mississippi, where rates of diabetes among those 65-74 years of age are the highest in the nation, baseline information on current practice patterns was required prior to the planning and implementation of programs designed to raise the level of care provided.<sup>17</sup> The purpose of this study was to gain this insight into current practice patterns relating to diabetes in the state.

Because the majority of diabetes patients in the US are cared for by primary care physicians, this analysis concentrated on four primary care clinics in the state.<sup>19</sup> The age and sex distribution of the beneficiaries in this study was similar to that found in other reports that used claims-based profiling to assess the frequency of diabetes monitoring services.<sup>13,15</sup> Compared to national data from the GAO, where 12.6 percent of beneficiaries were African American, approximately 27 percent in this study belonged to this ethnic group. While we did not analyze for differences in compliance rates with recommended monitoring services between ethnic groups, differences between Caucasians and African Americans have not been great in other reports.<sup>15</sup>

The American Diabetes Association (ADA) recommends, based on type of diabetes and glycemic control, a minimum of 2 to 4 quarterly visits annually.<sup>20</sup> Our data indicate that 69 percent of beneficiaries had at least 4 quarterly visits over a 6 quarter period, suggesting that visit frequency is not a major area that needs to be targeted for intervention.

Clinical practice guidelines suggest that testing for glycosylated hemoglobin be done 2-4 times annually and foot exams be performed with each visit.<sup>20</sup> This study indicates that testing for hemoglobin A1c or foot exams were not done in over 50 percent of beneficiaries. The frequency of A1c measurements did not seem to improve even among those who had more frequent quarterly visits (Figure 2). The percentage of those without recorded foot exams declined with the number of quarterly visits (Figure 2). However, more than 40 percent of those that had at least 6 quarterly visits still did not have a recorded foot exam. While the frequency of A1c testing could have been influenced, in part, by type of diabetes, mode of therapy, and metabolic control, an explanation for the

missed opportunities to perform a foot exam are unclear.<sup>19</sup> Interventions to improve overall monitoring of the hemoglobin A1c and the recording of foot exams could be two key areas target for improvement.

The ADA suggests annual screening for dyslipidemias and proteinuria.<sup>21-22</sup> Relative to monitoring of A1c and foot exams, screening for dyslipidemia (72 percent) and proteinuria (68 percent) among the beneficiaries in this study occurred with much higher frequencies. Variability in the nature of the tests performed however, was observed (Figure 3). Given the high mortality in diabetes due to cardiovascular disease, the ADA recommends screening with a full lipid panel (cholesterol, HDL, LDL, and triglycerides). However, only approximately a third of patients had this full profile recorded.<sup>4,21</sup> Discrepancy in how to screen for albuminuria exists in the literature.<sup>22-23</sup> The ADA recommends yearly urinalysis be performed, followed by a quantitative test for urinary albumin if the urinalysis is positive or negative for protein.<sup>22</sup> The recommendation by the National Kidney Foundation does not mention the urinalysis but suggests direct testing for albuminuria by the albumin-to-creatinine ratio as the screening test of choice.<sup>23</sup> Recent evidence also suggests that choice of methodology for albumin testing may be important.<sup>24</sup> In addition to improving the frequency of testing, clarification about the most effective way of screening for dyslipidemia and proteinuria are two areas that should be clarified to physicians as part of a quality improvement initiative.

Referral for dilated eye exam had the poorest compliance rate. The rate of 76 percent is worse than that reported in other published studies.<sup>14</sup> Given that the general recommendation from the American Diabetes Association is a referral for yearly dilated eye exam, this represents a key process measure that could be targeted for improvement.

The design of the present study did pose certain limitations. For example, it was a convenience sample, and the physicians who participated were volunteers. Because of this possible selection bias, estimates could be better or worse in a larger representative sample of primary care physicians. In addition, the methodology did not take into account the possibility that a beneficiary received recommended services elsewhere, did not factor in whether patients followed-up with recommended appointments, and cannot determine whether a foot exam was performed but simply not recorded. In addition, it is possible that record keeping oversights (e.g., a lab result not being recorded or filed) may have lowered documented services. Despite the limitations, the results highlighted several different areas that can be targeted for

quality improvement among the Medicare population in Mississippi. Interventions, including physician feedback and use of check sheets to record when specific services are to be performed, are currently underway. While interventions undertaken by the PRO will be targeted to the Medicare population, an anticipated collateral effect is that changes in practice patterns will be applied to all patients with diabetes seen by the primary care physician. Such programs are critical to a state like Mississippi that has the highest rate of self-reported diabetes in the nation.<sup>17,25</sup> A follow-up study evaluating the efficacy of these interventions is planned.

### Acknowledgment

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Appendix Table: Frequency of A1c tests and foot exams for Medicare beneficiaries with diabetes according to number of quarterly physician visits.

	Number of quarters seen						Totals
	1	2	3	4	5	6	
No. of beneficiaries	45	60	114	116	143	231	709
No. A1c tests							
0	29	32	57	57	76	128	379
1	14	22	16	17	26	42	137
2	2	4	20	12	17	15	70
3		2	20	18	13	10	63
4				8	2	7	17
5			1	4	7	13	25
6>					2	16	18
No. of foot exams							
0	34	40	68	59	80	102	383
1	11	17	31	28	43	50	180
2		2	12	19	11	35	79
3			1	8	3	15	27
4		1	2		2	11	16
5				2	3	5	10
6>					1	13	14

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## Coding Concepts

### Q. Please explain the difference or application of Modifiers -57 and -25.

A. Regarding our inquiry concerning Modifiers -57 and -25, the key lies in the intended use of the modifiers based on HCFA (Medicare) and AMA policies.

#### Modifier -57 Decision for Surgery

According to HCFA, this code is used to indicate that the decision for a major surgical procedure was made within 24-hours of the procedure. HCFA defines a major procedure as a procedure with 90 follow up days. In the Medicare program, the first 24 hours prior to the surgery are considered to be part of the procedure therefore non billable. Since Medicare recognizes the fact that a physician may need to first perform an evaluation of the patient before providing the service, they invented this modifier.

The AMA states this modifier is used to indicate the day the decision was made to perform the procedure.

#### Modifier -25 Separate, identifiable E/M service on the day of a procedure or other service.

This modifier is used with *minor* procedures. HCFA defines a minor procedure as one with zero or 10 days follow up time. To use this modifier, there must be a documented need to evaluate the patient on the same day as the procedure. The key is a separately, identifiable evaluation over and above just doing the procedure.

According to both HCFA and AMA guidelines, in the case of a new patient, this code may be used to evaluate the patient. In the case of an established patient, the guidelines state if there is a need to evaluate the patient for more than just the procedure, you could be entitled to an E/M service. For established patients presenting just for the procedure when the decision has already been made, you are not entitled to an E/M service.

The procedures you have described in your letter of June 10 are classified as minor procedures with zero to 10 days follow up care. For these procedures, the correct modifier would be -25 provided you had a separately documented evaluation of the patient for more than just doing the procedure.

The procedures you described in your letter are classified as minor procedures (zero to 10 days follow

up). For these services, the correct modifier would be -25 provided you had a separately documented evaluation of the patient for more than just performing the procedure

#### **Rule of Thumb:**

Use Modifier -57 for major procedures - follow days of 90 days or more.

Use Modifier -25 for minor procedures - follow up days zero or 10 provided there is documentation to support the need to evaluate the patient for more than just performing the procedure.

### Q. If a modified is used incorrectly resulting in payment of a claim, could this be construed as fraud by Medicare?

A. There is a fine line between fraud and abuse. Basically, fraud occurs when you knowingly report a service or procedure incorrectly or one you have not provided to a patient with the intent of receiving payment. Abuse occurs when an office submits a claim for services because of a lack of understanding of the rules.

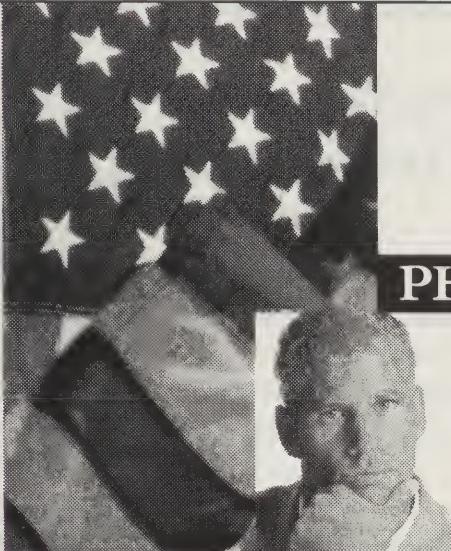
**Bottom line:** Offices will not be penalized for honest mistakes. However, when the office has been informed by an insurance company of the correct policy or procedure and continues to report services incorrectly, this would then be considered fraud by the carrier.

#### **CODING TIP**

While Modifiers are effective communication tools, they only work when an insurance company accepts them. Not all insurance companies follow AMA guidelines or HCFA requirements for code usage.

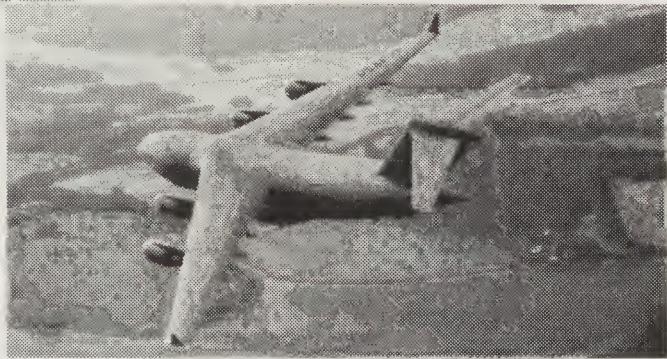
*Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, Adams & Associates, 3201 Cambridge Drive, Festus, MO 63028. Please include your name and phone number should additional information be required.*

*Wanda L. Adams, CPC, is owner and president of Adams & Associates, a health care consulting firm. She is a senior health care consultant and published author. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.*



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**Michael H. Carter, Jr., M.D.  
The President's Page**

## We Reap What We Sow

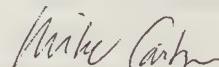
**M**any of you have heard me quote the great statesman Sir Winston Churchill who said, "You make a living by what you get but, you make a life by what you give."

As physicians, many of us are fortunate. I believe that our greatest fortune lies in being able to make a good life for those our work touches. We physicians are motivated by a call to service and we know that our responsibility does not stop at the hospital exit or the clinic door. But there is a much broader world just past the parking lot that needs our services as well.

The AMA Principles of Medical Ethics says it well: "A physician must recognize responsibility not only to patients, but also to society... A physician shall recognize a responsibility to participate in activities contributing to an improved community." For doctors with a busy practice, a growing family and a hectic schedule this can seem overwhelming. However, the rewards are great, and physicians have much to contribute.

You don't have to be a giant in medical research to make a giant contribution to the well-being of your community. You don't have to stand for office in MSMA to stand up for the right stuff. You don't have to get noticed to make a noticeable difference in someone's life. In fact, it is often those physicians who quietly go about the business of volunteering who have the greatest impact on their communities.

As physicians, ours is important work. That's why I believe we should not only do the hard work of healing the sick, but also the necessary work right in our own community and state. We can help build a better future for all those who depend on us and sustain us. Paraphrasing Churchill, "We reap what we sow." If we always remember what first drew us to medicine we will come to know the rich rewards of truly serving our fellow man.

A handwritten signature in cursive ink that reads "Mike Carter".

## **Seeking Nominations for the 1999 MSMA Award for Community Service**

The **Annual Physician Award for Community Service**, sponsored by Mississippi State Medical Association, is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

**Each recipient of the award is nominated by his or her component society** and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. All nominations should be submitted to the Mississippi State Medical Association by February 12, 1999.

**The award is a handsome plaque** which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A \$500 contribution** is also made by the association to a civic organization designated by the award recipient.

**Nominations should be submitted in writing.** There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

**Nomination supporting documents may include all or some of the following:** a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

**Nominations should be sent to MSMA**, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 12, 1999. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.

## Thomas Jefferson's Y Chromosome: The Power and Limitations of DNA Analysis

*"It fell to the lot of one Virginian to define America."*

C. Vann Woodward

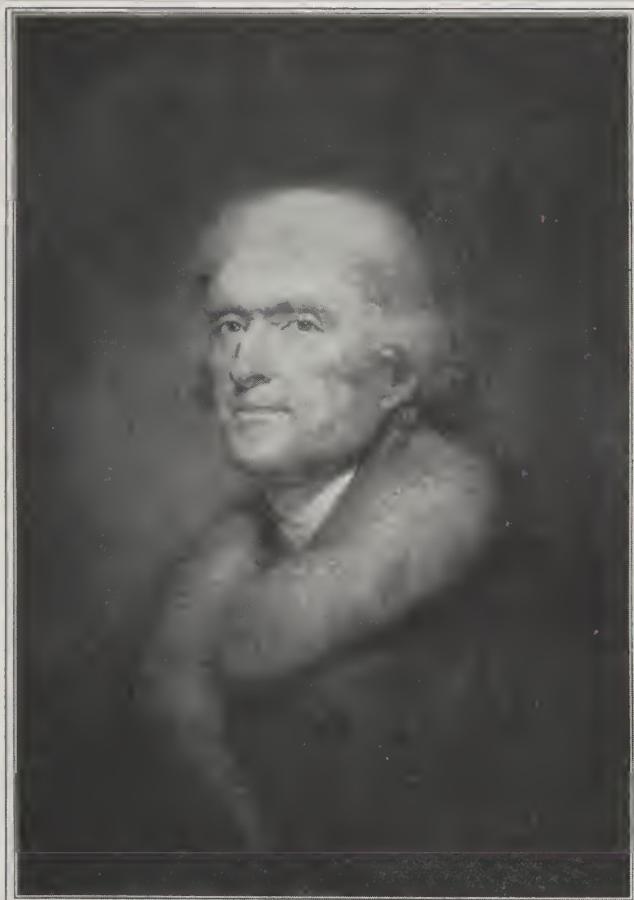
*"I laid it down as a law to myself, to take no notice of the thousand calumnies issued against me, but to trust my character to my own conduct, and the good sense and candor of my fellow citizens."*

Thomas Jefferson to Wilson C. Nicholas, June 13, 1809

A recent genetic study written by Dr. Eugene Foster and published in *Nature*, a respected British scientific journal, has brought this country's third president, Thomas Jefferson, to the fronts of our newspapers and as the subject of the nation's talk shows. Jefferson may rank at the very top of American immortals, with a richness of diversity of achievement in American life unequaled in government, religion, education, agriculture, science, and even philosophy. John F. Kennedy once entertained a large number of Nobel laureates at the White House and told them that the famous structure had never before played host to such a gathering of fine intellectual force—except when Thomas Jefferson had dined there alone. Jefferson's genius continues to illuminate our lives and his writings and life find relevance often in our own daily lives.

Foster's genetic article was entitled "Jefferson fathered slave's last child," despite the fact that the author readily admits that the title is misleading and that no such definitive statement can be made. The article created an uproar and was widely interpreted, or should I say misinterpreted, by the lay press as absolute proof of Thomas Jefferson's slave liaison. One nationally syndicated Gannett columnist, Deborah Mathis, called the paternity of Eston Hemings "settled" and called Jefferson "not only a founding father but a deadbeat dad." (Mathis, 8 November 1998) One commentator on *National Public Radio* even concluded that Jefferson was a "rapist" based on the genetic testing. *Newsweek* reported that "DNA evidence proved what some historians had suspected—Thomas Jefferson fathered a child with his slave Sally Hemings." (*Newsweek*, 16 November 1998) Even the usually more prudent and skeptical William F. Buckley swallowed the study whole, writing that Jefferson "had definitely procreated a son by Sally Hemings, one of his two hundred slaves." One writer in *The New Yorker* went so far as to write of the DNA results that "This finding abruptly ended the two hundred year old debate over whether the third President of the United States and his famously beautiful slave were lovers. To disbelieve now would require as much obtuseness as to believe, say, that a certain later President never came anywhere near a certain blue dress." An article in *The New York Times* wrote, "Science reveals the truth about an ancient scandal." (2 November 1998) *Time* concluded "Jefferson Did It" and *USA Today* wrote that the DNA tests "end nearly two centuries of speculation about whether President Thomas Jefferson had an affair with Sally Hemings." (2 November 1998) Of the nation's leading publications only the *Washington Post*, perhaps more experienced with political scandals, worded the findings correctly: "Tests Link Jefferson, Slave's Son: DNA Study suggests A Monticello Liaison." (1 November 1998)

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*



*Thomas Jefferson*  
From the portrait by Rembrandt Peale.

Complicating this wild sensationalism was its timing, on the eve of the American election, with most stories emerging on Sunday and Monday before the Tuesday election. Most of the political spin seemed to imply that if the author of our Declaration of Independence could engage in an illicit affair with a slave and lie about it, what was so different about President Bill Clinton doing the same? The timing at least hinted at a possible conspiracy to utilize the genetic study for broad political implications.

The Jefferson-Hemings tale is an old one, and long ago, during Jefferson's presidency, it had been alleged that Sally Hemings, a mulatto slave, had been his concubine. Journalist James Thomson Callender wrote in a September 1802 *Richmond Recorder*: "It is well known that the man, whom it delighteth the people to honor, keeps and for many years has kept, as his concubine, one of his slaves. Her name is SALLY. The name of her eldest son is Tom. His features are said to bear a striking though sable resemblance to those of the president himself. The boy is ten or twelve years of age...By this wench Sally, our president has had several children. There is not an indi-

vidual in the neighborhood of Charlottesville who does not believe the story." (Brodie, 349) The foremost Jefferson biographer, Dumas Malone, a Mississippian, dismissed the charges in a brief appendix in his monumental study, concluding that Jefferson "denied the story in a personal letter. Grandchildren of his later stated privately that Sally was in fact the mistress of one of his nephews." (Malone, 514) Said historian Virginius Dabney of Callender's charges: "In the grave at Monticello lie the bones of one whose fame is secure, no matter what slanderous falsehoods were spread against him long ago by a disappointed and unscrupulous office-seeker burning for revenge." (Dabney, 134) These original charges did find substantiation in family traditions of Jefferson's slaves, but by and large, the ancient debate among historians had largely been directed towards the belief that two of Jefferson's sister's sons, his nephews the Carrs, had fathered the slave children in question. No significant new objective evidence had come to light on the scandal until Foster published his study in *Nature*.

The journal *Nature*, a widely respected journal of science, made two clear editorial errors in publishing Foster's article: One, Dr. Foster et al's well written article was headed with the definitive title: "Jefferson fathered slave's last child." (27) Also, in an accompanying article in *Nature*, geneticist Eric Lander and historian Joseph Ellis were allowed to subtitle their article "DNA analysis confirms that Jefferson was indeed the father of at least one of Hemings' children." (13) This poor use of titles is highly inappropriate and misleading in a purported journal of science, especially when the article published states within it "We cannot completely rule out other explanations of our findings...for example, a male-line descendant of Field Jefferson could possibly have illegitimately fathered an ancestor of the presumed male-line descendant of Eston [Hemings]." (28) As well, the *Nature* articles reveal the problems of combining science and history and holding them equal, especially when the historical evidence is shaky at best.

Eugene Foster, M. D., a 71-year-old Charlottesville, Virginia pathologist who has served on the faculty at both University of Virginia (UVA) Medical School and Tufts in Boston, readily states, "I am not a geneticist and was not qualified to do this study." But he was a good researcher who gathered a respected group of geneticists to assist in his investigation. The study has a fascinating history. It was spawned at a dinner party conversation in Charlottesville, when Foster's friend Winifred Bennett asked if DNA could be used to solve the Jefferson-Hemings rumors. This was the spring of 1996 and the friends had been discussing the case of fellow

Charlottesville resident Anna Anderson Manahan, who maintained she was the daughter of the last Czar of Russia and went by the name Anastasia. Mitochondrial DNA had indicated that she was not related to the Czar.

Foster began a desultory effort, looking on *Medline* for similar studies and came to the conclusion by the spring of 1997 that the study could be done theoretically with autosomal DNA, but that it would be an unbelievably difficult task, involving exhuming bodies, multiple bodies, and taking at least 10 or 15 years to complete. However, in light of the fact that the DNA would be full of dilutions over this time period and complicated also by the fact that Jefferson's blood kin were considered the probable culprits, the trouble with usual DNA approaches looked overwhelming.

Foster's dampened enthusiasm received a boost after the 1997 Charlottesville Book Festival, after friend and fellow conspirator Bennett told the audience at a reading by Annette Gordon-Reed (who wrote a book on Jefferson and Hemings) that DNA would solve the case. The local press around Charlottesville picked up the comments and ran related stories about ways DNA could shed light on the rumors. One of those commenting on the story was Rolf Benzinger, a retired but then active member of the faculty at UVA's Biology Department. Benzinger told Foster that use of the Y chromosome might be the most useful tool for such a study. "Polymorphisms in the Y chromosome weren't as many as in autosomal DNA. It was no DNA fingerprint, but it would do better than complex blood typing," said Foster.

The project took off after geneticist Chris Tyler-Smith at the University of Oxford exchanged e-mails with Foster, recommending to him utilization of the Y chromosome, and offering to enlist European genetic scientists to assist him in the Jefferson study. Three methods of genetic testing were utilized: bi-allelic haplotyping, microsatellite short tandem repeats (STRs), and MSY1 (or minisatellites). These tests all separately found 19 different variable regions on the Jefferson Y chromosome.

Finding the Jefferson Y forced Foster into further detective work. Jefferson has no legitimate male line descendants living, his only son having died in childbirth. Foster enlisted genealogist Herbert Barger to track down a number of male line descendants of Jefferson's paternal uncle, Field Jefferson. This was the closest male line still intact. Brother Randolph Jefferson's male descendants had been considered, but the last male line descendant had died in the 1920s. The descendants of Field Jefferson agreed to participate.

Besides samples of the Jefferson Y, other Y chromosomes to be studied included that of Carr male line descendants, descendants of Thomas Woodson, and descendants of Eston Hemings, the latter two considered direct line descents of Sally Hemings. The Carr brothers, nephews of Jefferson, should have different Y chromosomes than their uncle, although sharing much mitochondrial DNA with him, and if either Carr fathered Eston Hemings or Tom Woodson, their Y should appear in descendants rather than the Jefferson Y. Five Woodsons in two different male lines of descent were used, and only one male line descendent of Eston Hemings was found. The Woodson family maintains that their ancestor, Thomas Woodson, was actually Thomas Hemings, the eldest son of Sally Hemings conceived during Jefferson and Hemings's stay in France and born at Monticello in 1790. The family notes he was sent away at the time of the Callender scandal in 1802 to a Randolph cousin married to a John Woodson in a nearby county and that this Tom Hemings later adopted the name Woodson. Eston Hemings Jefferson, one of only 5 slaves freed at Jefferson's death in his will, had after emancipation in the 1820s passed into white society in Madison, Wisconsin. (Bear,122) Eston Hemings, if he was Jefferson's son, was "legally white by then Virginia legal statutes" said Foster, who noted that Virginia laws concluded at that time that anyone with 1/8 or less African blood was legally white, and interestingly, this legal "whiteness" had no legal effect on the person's enslavement: they were still a slave.

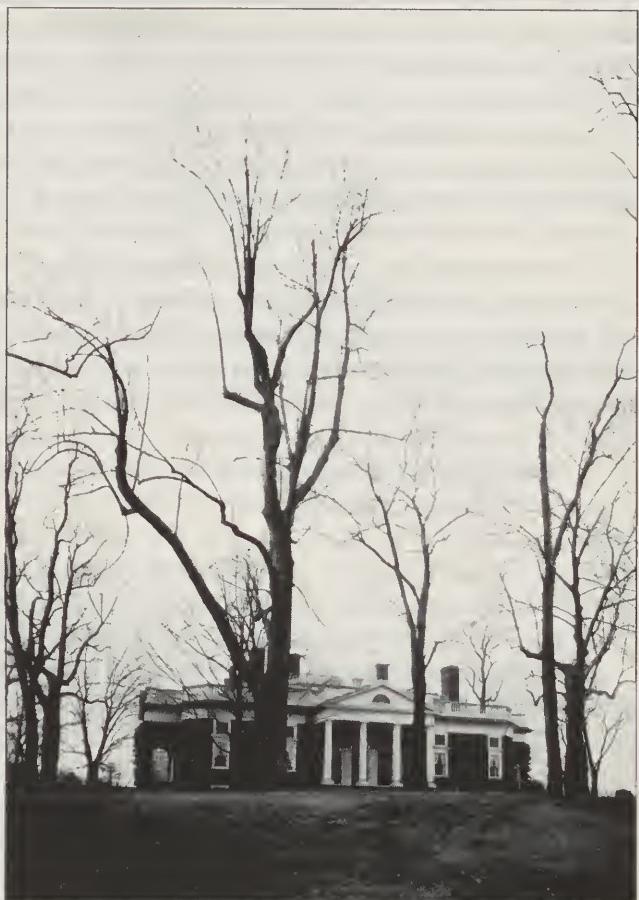
Foster's study, published in the 5 November 1998 issue of *Nature*, concluded that molecular findings failed to support the assertion that Thomas Jefferson was Thomas Woodson's father, but provided evidence that suggests that Jefferson could very well have fathered Eston Hemings. As well, the molecular studies with the Carr descendants did not share a Y chromosome with either Woodson or Heming's descendants, apparently undercutting past historical arguments frequently accusing them of fathering slave children with Hemings. The study, although full of interesting insights, was interpreted by the press as absolute proof of Jefferson's paternity of a slave child of Hemings, case closed.

The study's author was more hesitant about such conclusions. Foster wrote much what he told me in a letter to *The New York Times* published 9 November 1998, that "the genetic findings my collaborators and I reported in the scientific journal *Nature* do not prove that Thomas Jefferson was the father of one of Sally Hemings's children. We never made that claim. Nor do we believe that the Y-chromosome type we found in a Hemings descendant occurs only in members of the Jefferson family....There are many possible explanations for our findings, and it may turn out that some highly complicated and improbable theories are true." One of the lone voices noting the limitations of any

conclusions drawn from the study was an attorney named Thomas Moore, who wrote the *Times*: "No court of law would hold that Thomas Jefferson had a child by Sally Hemings. The most that is shown is that Jefferson's paternal grandfather or one of such grandfather's ancestors or descendants, sometime over the last 300 years or so, had a relationship that produced a male child who is an ancestor of one of the living and tested male descendants of Sally Hemings. This could have happened in the 17th, 18th, 19th or 20th centuries, and it could have bypassed both Thomas Jefferson and Sally Hemings." (6 November 1998)

Woodson's lack of connection to Jefferson opens up many questions, even if Woodson was who he said he was. Certainly, had Woodson male line descendants had the Jefferson Y, it would have made a very strong case that Thomas Jefferson was the Jefferson Y in question, for Sally Hemings's child "Tom" had been conceived in Paris and born in 1790. There is no evidence of another Jefferson Y, other than Thomas Jefferson, in Paris at that time. Said Foster, "One cannot discount the history that there was a slave in 1802, about 12 years of age, said to resemble Thomas Jefferson." Foster concludes that the genetic evidence is pretty strong that Thomas Woodson was not Jefferson's child, but the historical evidence does not substantiate conclusively that this Thomas Woodson was indeed the Thomas Hemings said to resemble Jefferson as a child. The scientific sword cuts both ways: just as Eston's Jefferson Y chromosome doesn't necessarily implicate Jefferson, neither does Woodson's non-Jefferson Y close the case that Hemings's first child Tom was not Jefferson's child. Tom Woodson may very well not be Tom Hemings.

Professor Hans-Georg Bock, Ph.D., M.D., a medical geneticist at University of Mississippi School of Medicine, stated that Foster's study "displays the power of genetics in answering questions of inheritance. It is a useful tool, but you must be prudent in your choice of projects." He did state that any genetic study must have strict guidelines to ensure the quality of the study to rule out human error affecting the results. Bock felt use of the Y chromosome an interesting approach: "Y makes it an easier study. The Y chromosome flows generally intact through generations with hundreds of markers on the Y." While Bock concurred that the genetic study appeared to provide evidence "compatible" with Jefferson fathering the child, he strongly stressed that the study does not and cannot "prove" such, and it is possible that another male with a similar Y chromosome could have fathered the child. "Genetics can rule out paternity of the Woodson descendants, but it cannot prove Jefferson's paternity of



*Winter View of the Great Trees at Monticello  
These were planted by Thomas Jefferson.*

Eston Hemings."

He also felt the editors at *Nature* had not done a good job in appropriately presenting the findings. Said Bock: "I don't like to see this in a scientific journal. The headline is misleading sensationalism. It is not accurate and irresponsible, and it is unfortunate this was not caught by the editors." Bock concluded, on reading the article, that if the study did not have human error involved, that the appropriate conclusion was the "probability that the Jefferson Y was involved in fathering Eston Hemings and that the Jefferson Y was not involved in fathering Thomas Woodson."

Foster largely agreed with most of Bock and this author's assertions of the limitations of the study: "We could not hope to solve the argument. Our study was intended to throw the weight of the historical evidence one way or the other with some objective data."

Foster's safeguards to decrease human error were many. He drew every specimen of blood himself and immediately labeled the vials with a random code number. He personally brought the vials to a genetic lab at UVA

where the DNA was extracted. He carried the aliquots of each specimen on his carry-on baggage on a plane trip to England and personally carried the specimens to his collaborators' labs in Oxford, and throughout the trip the specimens "were never out of my sight." He considered the "scientific part" of his study "unassailable."

Foster concludes: "The media hype went way too far. However, I do think that Thomas Jefferson is the father of Eston Hemings but we can't prove it. The evidence favors the idea and the evidence favors the idea that he was not the father of Thomas Woodson, but it doesn't prove it. My gripe with the press is that they interpreted my study as absolute proof rather than objective evidence suggesting a link between Jefferson and Hemings."

He expressed his own dissatisfaction with the title for his article and admits the imprecise wording may have contributed to many of the misinterpretations by the lay press. "The title of the article the editors of *Nature* used with my article was not consistent with the article nor our findings. My title was less definitive and I was not happy with their headline. *Nature* has a million editors and the ball was dropped by the production staff." He also noted that he was not responsible for a companion article which accompanied his article and makes it clear he was not "allowed to read it prior to publication."

Regarding the November election appearance of the article and suggestions that the article was printed at that time to help vindicate President Clinton on the eve of the election, Foster calls this an "accident totally." He states: "The paper was accepted in September 1998. The publication of the article was planned for December but before we had finished revising the article, we learned that there had been a leak at *Nature* of the findings to *U. S. News and World Report* and that this magazine planned to publish their findings the last week of October. The publication date of the *Nature* article was moved up to November 5 to prevent *U. S. News* from scooping the original article."

Foster summed up his article: "My interpretation of the results I think is appropriate: we did not prove Thomas Jefferson fathered Eston Hemings. I feel the results, however, do throw the weight of probability to the conclusion that Thomas Jefferson was likely Eston Hemings's father and was not likely Thomas Woodson's."

The study has focused attention on often neglected male Jeffersons living near Monticello. There is no doubt that brother Randolph Jefferson was a presence at Monticello and had sons with access to Monticello. Strong possibilities are Randolph Jefferson, his many sons, and possible descendants of slave descendants of Jefferson's father or ancestor, if such existed. Two letters from Thomas Jefferson to his brother in 1807 revealed strong probabilities that Randolph was present at Monticello when Eston was perhaps conceived. In February 1807, Thomas Jefferson writes his brother, "In hopes I shall have the pleasure of seeing you then at Monticello," and a letter dated 12 August 1807, near the time Eston Hemings was conceived, invited Randolph to come visit Thomas and sister Anna Scott Marks at Monticello. (Mayo, 19, 21) Randolph, born in 1755, died in 1815, and little is known of him, outside of the fact that he was a substantial farmer across the James River from Monticello in nearby Buckingham County. (Mayo, 5)

Randolph and Thomas Jefferson's father Peter (1707-1757) left them considerable slave property: each son received about 20. (Mayo, 2) As well, what slaves did Peter Jefferson inherit from his own father Captain Thomas Jefferson (1679-1731) of Virginia and his father Thomas Jefferson, who was a farmer who settled in Henrico County Virginia by 1677? (Brogan and Mosley, 238) While there is no past evidence that Peter or his antecedents fathered slave children, the presence of the Jefferson Y chromosome in Eston may be explained by such. The presence at Monticello of twenty slaves long in the Jefferson family, many mulatto, with many males and possible Jefferson Y carriers, underscores the imprudence of centering simply on Thomas Jefferson alone as the source of the Y in Eston. Skepticism has always been an integral part of scientific study, and any absolute conclusions on the Jefferson-Hemings argument should be viewed with great skepticism.

Foster concluded that his article served its purpose: "It ought to stimulate a lot more work on Jefferson. A lot of people are very interested in Randolph Jefferson and his sons and before the study, no one suggested Randolph might have fathered these children. Usually just the Carrs were considered."

Perhaps one of the best assessments of the tests was made by Dr. Dan Jordan, a fellow Mississippian who is president of the Thomas Jefferson Memorial Foundation and who lives on the grounds at Monticello. He stated that the Thomas Jefferson Memorial Foundation, which owns and operates Monticello, will "in the Jefferson tradition... follow truth wherever it may lead us." Jordan concluded: "The Thomas Jefferson-Sally Hemings controversy is now almost two-hundred years old, and it is one about which honorable people have disagreed. Few Americans have been more vigorous advocates of scientific pursuits than Jefferson. To reduce the mysteries of the past and move us all closer to the truth is in the spirit of Thomas Jefferson."

Jefferson will continue to baffle Americans, and his own private life, what can be established about it, may never

be sorted out definitively. He was a widower for the second half of his life and a relationship with a slave, a half sister of his late wife, does not seem far fetched at all. However, 200 years after the fact, we simply have limitations on what can be said definitively happened, and this genetic study does not prove any such relationship. It will, however, force the better students of history to look objectively at the evidence, and if they do, the Jefferson-Hemings relationship will have to be viewed as a very distinct possibility. Other Jefferson males will be studied in more detail to chart their possible relationships with Hemings. But all will throw more light on Jefferson, his life at Monticello, and the enigmas which embodied this central founding father.

Science has its place, but also very real limitations. Skepticism remains a healthy aspect of scientific inquiry. Our society desires, in some pathetic way, to believe that science can answer all questions absolutely. It can't. The Foster study is interesting and provides fascinating and revealing data about the Jefferson-Hemings relationship. But in no way is Foster's study conclusive evidence that Jefferson is or is not the father of Sally Hemings's children. The media has much overblown the significance of the study, and the absoluteness of conclusions drawn. Good history still has its place, and neither good history nor good science are benefited by sensationalism.

—Lucius M. Lampton, M.D.  
Associate Editor

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## Meet the Staff

### Alicia A. Thames, Executive Assistant

**Years with Company:** Three and a half.

**Previous Position:** Prior to accepting the position as Executive Assistant for MSMA, I worked with non-profit agencies and volunteers as Assistant to the Director of Allocations for the United Way of the Capital Area.

**Business Philosophy:** There is not a *right* way to do a wrong thing.

**Favorite Thing About My Job:** Being part of a team. We all seem to compliment each other.

**Hobbies:** Coloring, playing chase and having tea parties. Spending quality time with my daughter, Laura, takes top billing.

**Hometown:** I grew up and have resided nearly all my thirty years in Mendenhall, Mississippi. It's so funny when I remember my words, "I can't wait to get out of this small town and get into the real life of the city." Now that I have my daughter - well, there is no where I would rather be than in this small, wonderful, little town. My family and I all live within a five-mile radius - nothing is better.



**Family:** My daughter, Laura, is 18 months old.

**Little Known Fact About Yourself:** I enjoy keeping up my sign language. I am a volunteer at the Mississippi School for the Deaf and have a good friend who is deaf. She keeps me on my toes. My goal is to be able to sign well enough to translate at my church and the New Stage Theater (big challenge).

**Most Valued Virtue:** Loyalty

**Heroes:** My parents, by far. Of course, I am biased. But, I am truly blessed to have the family I have and that includes my sister, Pam, and twin, Tricia.

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# Looking Back at Last Year's Legislative Wins

**Thanks to Your Support MSMA Passed the First Statute of Repose Bill in a Decade**

**STATUTE OF REPOSE BILL      HB 1194**

MSMA's seven year Statute of Repose law, which went into effect July 1, 1998, sets a finite time frame in which claims of medical malpractice can be filed. Claims must now be filed within "*two years from the date the alleged act, omission or neglect shall or with reasonable diligence might have been first known or discovered, and... in no case more than seven years after the alleged event.*"

Two exemptions to the seven-year rule were also included in the new law. An exemption for foreign objects is not expected to adversely effect physicians. Statistics provided by Medical Assurance Company of Mississippi note that during the past 20 years, no charge of medical malpractice involving a foreign object has been filed with MACM more than seven years after the alleged event. Additionally, 94 percent of all cases involving a foreign object filed with MACM in the past 20 years were discovered in two years or less.

The second exemption allows claims to be filed two years from discovery (with no seven-year limitation) when information regarding the alleged act or omission was fraudulently concealed. The new law states, *In the event the cause of action shall have been fraudulently concealed from the knowledge of the person entitled thereto, the cause of action shall be deemed to have first accrued at, and not before, the time at which such fraud shall be, or with reasonable diligence should have been, first known or discovered.*

**Passage of Utilization Review Bill Means Out-of-State Reviewers Must Get Mississippi License**

**U.R. BILL**

**HB 1194**

Out-of-state physicians conducting utilization review on Mississippi cases must now be licensed by the State Board of Medical Licensure. MSMA rallied to overcome tremendous opposition led by the insurance and HMO lobbies to pass the bill, commonly known as MSMA's U.R. bill. Beginning January 1, 1999, the new statute will ensure that a reviewer determining medical necessity is a physician licensed by this state and subject to Mississippi's Medical Practice Act. It will also require reviewers to respond to a physician's request for approval within 14 calendar days.

*The new law states that, No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in Mississippi. The physician who made the adverse determination shall discuss the reasons for any adverse determination with the affected health care provider, if the provider so requests. The physician shall comply with this request within fourteen (14) calendar days of being notified of a request.*

## **Medicaid, Private Insurance to Cover Low-Income Children CHILDREN'S HEALTH INSURANCE SB 2174**

A statewide program that will soon be implemented in Mississippi will provide health coverage for children of low-income families that do not currently qualify for Medicaid and have no other health care coverage. A combination of the original House and Senate proposals, the new program expanded Medicaid coverage to 16, 17 and 18-year-olds whose family income is at or below 100 percent of the federal poverty level through Aid to Families with Dependent Children. Approximately 6,000 children qualify for this expanded coverage.

The act also creates the **Mississippi Children's Health Insurance Program Commission** which has submitted a plan for covering additional children from low-income families to the federal office of Health and Human Services. The Commission will have the authority to solicit bids and contract with private insurers to provide the necessary health care services.

All children that qualify for the **Children's Health Insurance Program (CHIP)** will have coverage for 12 continuous months. Coverage is required to be at least equal to that provided under Medicaid but must also include early and periodic screening and diagnosis services, vision and hearing screening, eyeglasses and hearing aids, preventive dental care and routine dental fillings.

## **Statewide Trauma System Established TRAUMA CARE HB 966**

An improved statewide communication system will enable emergency response workers and physicians to determine the best hospital to treat a victim's injuries and prepare hospital personnel for that arrival. Only \$2.2 million was allocated for the development phase of the system to take place in FY 1999. An additional \$6.5 million must be appropriated in the 1999 legislative session to reimburse physicians and hospitals for uncompensated emergency trauma care.

## **Fees Increased for Impaired Physicians IMPAIRED PHYSICIANS FEE BILL SB 2391**

This bill allows the State Board of Medical Licensure to increase the license renewal fee for physicians and earmarked the increase to support the impaired physicians program. Renewal fees are expected to be raised \$40.

## **Other Health Related Bills That Passed**

### **BYSTANDING CAREGIVERS NOTIFIED OF EXPOSURE HB 1029**

A "*bystanding caregiver*" was added to the list of health care personnel to be notified if the person to whom care is rendered is subsequently diagnosed as having an infectious disease transmittable by blood or other internal body fluids. "*Bystanding caregiver*" was defined as a "*layman who provides care to an injured person at the scene of an emergency before the arrival and rendering of emergency medical services by a licensed or certified emergency medical services provider.*"

### **BLOOD ALCOHOL LEVEL REDUCED FOR MINORS HB 990**

Mississippi's implied consent law was amended to lower the blood alcohol content level allowed by minors driving automobiles. The zero tolerance language sets the legal limit of alcohol registering on a breath test at .02 percent for minors and .10 percent for adults.

### **AGE OF SEXUAL CONSENT HB 834**

This new law established a task force to consider whether raising the age of consent to an age above 16 would likely prevent and reduce the incidence of teenage out-of-wedlock pregnancies. The new law also defines the crime of statutory rape as when anyone age 17 or older has sex with a child who is age 14 to 16 and is three years or more younger. Penalties are also increased to five years in prison or \$5,000 for perpetrators age 18 to 21, 30 years in prison or \$10,000 for perpetrators age 21 or over. The penalty for rape involving a child under the age of 14 and more than two years younger than the perpetrator is increased to a minimum of 20 years to life in prison.

## cont. . . Other Health Related Bills That Passed

### HIV/AIDS FUNDING

**HB 1192**

This bill appropriated \$750,000 to the State Department of Health for HIV/AIDS medications and disease prevention.

### ORGAN DONATION

**HB 412**

This new law revises procedures regarding the identification of potential organ donors.

### DIABETES, IMMUNIZATIONS, MAMMOGRAPHY INSURANCE

**SB 2215**

All insurers in Mississippi are now required to offer optional coverage for diabetes treatment including equipment, monitoring supplies, and self-management education and medical nutrition therapy. Additional options for child immunizations against ten diseases and annual mammography screening for all women over age 35 are also required to be offered.

## Plan to Attend:

# MSMA & MHA Health Issues Forum

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**For more information see  
the inside, back cover of this  
JOURNAL MSMA.**



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### MSMA Alliance Wins Awards at Southern Medical Association Meeting



(left to right) Jenny Kalaycioglu, President, SMA Auxiliary; Emily Shelton, Past President, SMA Auxiliary (1991-92); Peggy Crawford, Councilor, and Merrell Rogers, President-elect, SMA Auxiliary. Emily and Peggy received the Award of Excellence for their work in the Breast Cancer Awareness project. They were presented with an inscribed Waterford Bowl. This is the first time this award has been given in the 1990's. When asked about the award, Mrs. Crawford replied, "I don't deserve this." My teammates in the Alliance and the Mississippi Extension Service did the work."

Peggy Crawford, Mississippi Health Education Councilor and Nancy Brinker, Founder of the Susan B. Komen Breast Cancer Foundation. Mrs. Brinker was the speaker at the Auxiliary House of Delegates. A Health Forum had been held prior to her speech. The members voted to continue the current Breast Cancer Awareness project for five years.

Belle Chenault, Past President of the American Medical Association Auxiliary (1969-70) and Past President of Southern Medical Association Auxiliary (1959-60) and Nancy Lindstrom, SMA Auxiliary Finance Committee Chair. Nancy was recently appointed to the American Medical Association AMPAC Board by the AMA Board of Trustees. Mrs. Chenault was a member of this Board.





**The Mississippi Delegation to the Southern Medical Association Auxiliary Annual Session.** The 92nd Annual Scientific Assembly of the Southern Medical Association (SMA) and the 74th Annual Session of the Auxiliary convened in New Orleans, Louisiana on November, 18, 1998. SMA is the largest multispecialty organization in our country that serves physicians through education. Sixteen states and the District of Columbia comprise the majority of the membership, but other states are represented in the 40,000 members. The SMA Auxiliary's primary focus is health education on breast cancer awareness, Doctors' Day and Medical Heritage.



**Martha Clippinger, Merrell Rogers, Cathy Gersh, and Peggy Crawford** display award certificates for first place in the state category for Breast Cancer Awareness and third place in the Confederate Hospital Restoration projects. Lee County Medical Alliance won second place for its Doctors' Day project.

## **Information and Quality HEALTHCARE Time to Mark Calendars for Special Events**

I.Q.H. has scheduled a Quality Forum June 4 and 5, 1999. The two-day event will encase the traditional quality showcase event which includes special emphasis on the health care improvement projects. The annual membership session, programs on quality, nationally recognized speakers, and continuing education sessions will also be a part of the forum, which will be held at the Jackson Hilton.

### **Several Courses Scheduled Throughout 1999 by I.Q.H. May Be of Interest to Physicians for Their Office Staffs**

Fundamentals of office compliance will be presented Jan. 14, March 25, May 13, July 22, Sept. 23, and Nov. 18.

Medical terminology classes have also been set throughout the new year. A basic 12-week course will begin Feb. 2 and continue one night each week. Each session will address body systems, directional terms, pharmacology, procedures and abbreviations applicable to the system.

Another series of medical terminology classes will be available for attendance at single sessions or for the entire course. The class will meet one day a month through November 1999.

Qualified instructors will teach the courses. Registration details and further information can be obtained by calling 601-354-0304.

### **Medicare Sixth Scope of Work Begins in 1999**

This new year will also welcome a new Sixth Scope

of Work from the Health Care Financing Administration. An extension of the Fifth Scope will continue through July before the new program begins.

Six national clinical priorities will be included: acute myocardial infarction, congestive heart failure, pneumonia, stroke/transient ischemic attack/atrial fibrillation, diabetes, and breast cancer. Indicators have been developed, with both the baseline and amount of improvement to be measured by HCFA. Intervention methods will be selected by the PROs, who will also be required to conduct two-state-specific projects, one expanding on a national topic and another dealing with a clinical priority area of the PRO's choice.

For the state-specific projects, the PRO will identify the quality indicators, measure the baseline, develop and conduct the intervention and remeasure the improvement after the intervention.

PROs will also participate in a new HCFA goal of reducing payment error rate for inpatient hospital services to five percent or less by the year 2002.

PROs are to continue reviewing beneficiary complaints and appeals, educating beneficiaries about their right to PRO review, and providing information to the medical community.

Special studies initiated by either HCFA or the PRO will be a part of the Sixth Scope. These may involve pilot improvement projects, payment error prevention (PEP) efforts outside the hospital environment or special beneficiary communication activities.

*—James S. McIlwain, M.D.,  
President, Principal Clinical Coordinator*

# New Members

**ARU, GIORGIO M.**, Jackson. Born Cagliari, Italy, Nov. 28, 1950; MD, Univ. of Padova, Padova, Italy 1975; general surgery residency, same 1976-80 and cardiovascular surgery residency, same, 1977-83; cardio thoracic surgery residency Emory School of Medicine, Atlanta, GA, 1984-85 and Univ of Oregon, Portland, OR, 1985-86, and University of Penn, Philadelphia, Pa, pediatric carpio thoracic surgery 1986-87; thoracic surgery residency, University of MS Medical Center, Jackson, MS, 1996-98; elected by Central Medical Society.

**BURNS, BETH ANN**, Biloxi. Born Chicago, IL, February 9, 1968; DO Nova - Southeastern University School of Medicine, Ft. Lauderdale, FL, 1995; internal medicine residency, Mt Sinai Medical Center, Miami Beach, FL, 1995-98; elected by Coast Counties Medical Society.

**CASSAVA, MARGARET K. O.**, Greenville. Born Augusta, GA, October 27, 1964; MD University of South Carolina, Columbia, SC, 1991; psychiatry residency University of South Carolina & Wm. S. Hall Psychiatric Inst., Columbia, SC child psychiatry residency 1992-94; child psychiatry residency East Carolina Univ. School of Medicine, Greenville, NC, 1995; elected by Delta Medical Society.

**CASTLE, MONA M.**, Oxford. Born October 28, 1961, Starkville, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1989; family medicine residency, UMC Medical Society, Jackson,

MS, 1989-92; elected by North MS Medical Society.

**CHEN, YEN CHOU JOE.**, Biloxi. Born June 26, 1996, Taiwan; MD University of Texas School of Medicine, Galveston, TX ; transitional internship John Peter Smith Hospital, Dallas, TX, 1993-94; anesthesiology residency , Univ of Texas Southwestern, Dallas, TX, 1994-97; pain management fellowship, Univ of Florida, Gainesville, FL, 1997-98; elected by Coast Counties Medical Society.

**CHRIST, ELIZABETH A.**, Jackson. Born Lake Charles, LA, Nov. 24, 1964; MD Louisiana State University School of Medicine, New Orleans, LA,, 1990; pediatric residency, same, 1990-94; pediatric critical care fellowship, Univ. of Tennessee Medical Center-Labonheur Hospital, New Orleans, LA, 1994-97. Elected by Central Medical Society.

**CISEK, VICTOR J.**, Tupelo. Born Poland, July 3, 1960; MD Mt. Sinai School of Medicine, New York City, New York, 1985; physician medicine & rehabilitation residency, New York University-Rusk Institute of Rehabilitation 1986-89; elected by Northeast MS Medical Society.

**COLE, PETER A.**, Jackson. Born Havre de Grace, MD June 19, 1961; MD University of Miami School of Medicine, Miami, FL, 1990; orthopaedic surgery residency, Univ-Rhode Island Hospital, Providence, RI, 1992-97; elected by Central Medical Society.

**DENNIS, LAURENCE L.**, Booneville. Born Memphis, TN, May 30, 1961; MD University of Tennessee School of Medicine, Memphis, TN, 1990; internal medicine residency, same, 1990-93; elected by Northeast MS Medical Society.

**DICKENS, MARTHA D.**, Jackson. Born Jackson, Ms, March 18, 1953; MD University of Mississippi School of Medicine, Jackson, MS, 1984; family medicine residency, Floyd Medical Center, Rome, GA, 1984-87; elected by Central Medical Society.

**DUNDEE, DAVID THOMAS**, Derma. Born Philadelphia, PA, May 15, 1964; MD Temple Medical School, Philadelphia, PA, 1990; anesthesiology residency, New York Hospital Medical Center, New York, NY, 1990-93; nuclear medicine fellowship, Temple Univ. Hospital, Philadelphia, PA, 1994-95; elected by Northeast MS Medical Society.

**EDALAT, VEIVAN**, Prentiss. Born Tehran, Iran, March 27, 1966; MD, University of Hamburg School of Medicine, Hamburg, Germany, 1992; internal medicine residency, Memorial Hospital, Worcester, MA, 1996-97; elected by Central Medical Society.

**FRILOUX, BRIAN K.**, Baldwyn. Born Ft. Sill, OK, January 1, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1994; surgery internship one year, Baptist Hospital Atlanta, GA; family practice residency, Emory Medical Center, Atlanta, GA, 1995-97; elected by Northeast MS

Medical Society.

**GIBSON, LARRY F.**, Raleigh. Born Bay Springs March 19, 1948; MD University of Arkansas School of Medicine, Little Rock, AR, 1983; family medicine residency, same, 1988-91; elected by South MS Medical Society.

**GOEL, DINESH K.**, Jackson. Born India, October 9, 1945; MD K C Medical College, India, 1967; elected by Central Medical Society.

**HOEHNER, PAUL J.**, Jackson. Born Kankakee, IL, January 14, 1961; MD Johns Hopkins School of Medicine, Baltimore, MD, 1986; anesthesiology & critical care medicine, same, 1987-90; cardiovascular anesthesiology fellowship, same, 1990-91; elected by Central Medical Society.

**LEE, MAKAU P.**, Jackson. Born April 11, 1958; MD Baylor College of Medicine, Houston, TX, 1986; internal medicine residency, same, 1986-89; gastroenterology fellowship, Univ. Texas-Southwestern, Dallas, TX, 1989-92; elected by Central Medical Society.

**LEWIS, ADAM I.**, Jackson. Born Cambridge, MA, February 10, 1964; MD Georgetown University School of Medicine, Washington, DC, 1990; neurosurgery residency, University of Cincinnati Medical Center, Cincinnati, OH, 1990-96; elected by Central Medical Society.

**LIVINGSTON, MICHAEL C.**, Jackson. Born Tallulah, LA, June 30, 1958; MD Meharry Medical College of Medicine, Nashville, TN, 1985; ob-gyn residency, Prov-

idence Hospital, Southfield, MI, 1985-89; elected by Central Medical Society.

**MANNING, IRVIN R.**, Flowood. Born Rolla, Missouri, January 17, 1967; MD University of Texas Medical Branch, Galveston, TX, 1994; anesthesiology residency, same, 1994-98; elected Central Medical Society.

**MANSOUR, KATHLEEN A.**, Greenville. Born Meadowbrook, PA, July 26, 1962; MD University of Penn. School of Medicine, Philadelphia, PA, 1988; internal medicine residency, Beth Israel Hospital-Harvard, Boston, MA, 1988-91; cardiology fellowship, same, 1991-94; elected by Delta Medical Society.

**MANSOUR, MICHAEL**, Greenville. Born Greenville, MS, December 27, 1956; MD University of Mississippi School of Medicine, Jackson, MS, 1984; flexible internship, one year, LSU-Conway Hospital, LA.; internal medicine residency, Ochsner Foundation Hospital, New Orleans, LA, 1985-88; cardiology fellowship, University of Florida, Gainesville, FL, 1988-90; interventional cardiology, Harvard Medical School - Beth Israel Hospital, 1990-91; elected by Delta Medical Society.

**MARSHALL, DEREK E.**, Jackson. Born January 31, 1967, St. Louis, MO; MD University of Tennessee School of Medicine, Memphis, TN, 1994; transitional internship, University Hospital, Cleveland, OH, 1994-95; anesthesiology residency, University Medical Center, Jackson, MS, 1995-98; elected by Central Medical Society.

**MASON, JOHN L.**, Hattiesburg. Born Jackson, MS, October 3, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; ophthalmology residency, University Medical Center, Jackson, MS, 1991-92; elected by South MS Medical Society.

**McEACHERN, ROBERT C.**, Jackson. Born Cleveland, MS, September 2, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1992; internal medicine residency, same, 1992-95; pulmonary fellowship, same, 1995-97; critical care fellowship, LSU Medical Center, Shreveport, LA, 1997-98; elected by Central Medical Society.

**MITIAS, HANNA (JOHNNY) M.**, New Albany. Born Waterloo, Ontario, Canada, March 19, 1967; MD University of Mississippi School of Medicine, Jackson, MS 1993; orthopaedic surgery residency, Campbell Clinic, Memphis, TN, 1993-98; elected by Northeast MS Medical Society.

**MORA, MARCELO**, Poplarville. Born Ecuador, August 6, 1936; MD Universidad Central, Quito, Ecuador, 1963; elected by Pearl River Medical Society.

**NORTON, MARK W.**, Laurel. Born Laurel, MS, November 23, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1995; internal medicine residency, University of Tennessee Medical Center, Memphis, TN, 1995-98; elected by South MS Medical Society.

**NARAYANASWAMY, T. R.**, Hattiesburg. Born November 14, 1946; MD Thanjavur Medical College-University of Madras, 1970;

internship one year, St. Francis Hospital, Evanston, IL; medicine residency, Henry Ford Hospital, Detroit, MI, 1975-76; elected by South MS Medical Society.

**O'SULLIVAN, PATRICK J.**, Oxford. Born Dublin, Ireland, March 17, 1939; MD University College, Dublin, Ireland, 1964; medicine residency, St. Vincent Hospital, Dublin, Ireland, 1965-67; neurology residency Strong Memorial Hosp., Univ. Rochester, Rochester, NY, 1967-69 & 71-72; elected by North MS Medical Society.

**PATEL, AMI R.**, Jackson. Born India, November 1, 1963; MD, MS Ramaiah Med College, Bangalore, India, 1987; internal medicine residency, Coney Island Hospital, Brooklyn, NY, 1989-92; nephrology fellowship, University Medical Center, Jackson, MS, 1992-94; elected by Central Medical Society.

**PETRO, JOHN V.**, Hattiesburg. Born Hattiesburg, MS, August 24, 1953; MD University of Mississippi School of Medicine, Jackson, MS, 1980; ophthalmology residency, University Medical Center, Jackson, MS, 1980-82; elected by South MS Medical Society.

**PRIDJIAN, ARA K.**, Gulfport. Born Chicago, IL, January 14, 1958; MD University of Illinois School of Medicine, Chicago, IL 1978; general surgery residency, Univ. of Illinois Hospital, Chicago, IL, 1983-89; thoracic surgery residency, Univ. of Michigan Hospitals, 1989-91; pediatric thoracic surgery fellowship, same, 1991-92; elected by Coast Counties Medical Society.

**RAMSAK, AMY K.**, Gulfport. Born Lexington, KY, Feb. 7, 1961; MD East Tennessee School of Medicine, Johnson City, TN, 1995; internal medicine residency, same, 1995-98; elected by Coast Counties Medical Society.

**RICHERT, ALLEN C.**, Jackson. Born Jennings, LA, July 8, 1968; MD Louisiana State University School of Medicine, Shreveport, LA, 1993; psychiatry residency, Dartmouth-Hitchcock Medical Center, NH, 1993-97; sleep disorders fellowship, same, 1997-98; elected by Central Medical Society.

**RINKER, RONALD D.**, Pascagoula. Born Pennsylvania, July 15, 1963; MD Tulane University School of Medicine, New Orleans, LA, 1989; interned, one year, National Naval Med. Center, Bethesda, MD; internal medicine residency, Tulane Medical Center, New Orleans, LA, 1993-95; gastroenterology & hepatology fellowship, same, 1995-98; elected by Singing River Medical Society.

**RUNNELS, RUDOLPH S., JR.**, Jackson. Born Jackson, MS, September 4, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1993; general surgery residency, Univ. of Tennessee Medical Center, Memphis, TN, 1993-96; plastic surgery residency, same, 1996-98; elected by Central Medical Society.

**SHAIKH, MUHAMMAD A.**, Vicksburg. Born Pakistan, November 20, 1959; MD Sind Medical College, Karachi, Pakistan, 1985; internal medicine residency, Bronx-Lebanon Hospital Center, Bronx, NY, 1991-94; infectious disease fellowship, Mt Sinai Medi-

cal Center, New York, NY, 1994-96; elected by West MS Medical Society.

**SPURRIER, DANIEL R.**, Greenville. Born January 23, 1954; MD East Carolina University School of Medicine, Greenville, NC, 1982; interned one year, same; general surgery residency, East Carolina Univ., Pitt Memorial Hospital, Greenville, NC, 1983-84 and East Virginia Grad School of Medicine, Norfolk, VA, 1984-89; cerebrovascular surgery fellowship, Univ. of Florida Medical Center, Gainesville, FL, 1988-89; elected by Delta Medical Society.

**TUCKER, JAMES D.**, Ridgeland. Born Greenville, TN, November 2, 1943; DO Kansas City college of Osteopathic Medicine, Kansas City, MO, 1978; elected by Central Medical Society.

**UDDIN, SAID**, Jackson. Born Pakistan, May 5, 1963; MD Sind Medical College, Pakistan, 1988; internal medicine residency, Muhlenberg Hospital, Plainfield, NJ, 1982-95; rheumatology fellowship, Univ. of Medicine & Dentistry, New Jersey, 1995-96; elected by Central Medical Society.

#### Deaths:

**LONG, JOHN W.**, Jackson. Born May 11, 1915; MD Tulane University Medical School, New Orleans, LA, 1941; died November 18, 1998, age 83.

**TATUM, NANCY O'NEAL**, Jackson. Born March 11, 1950; MD University of Mississippi School of Medicine, Jackson, MS, 1980; died November 25, 1998, age 48.

## Personals

**Henry Flautt, Jr., M.D.**, Internal Medicine, has been elected Chief of Staff of Greenwood Leflore Hospital for 1998-1999.

**Yoshinobu Namihira, M.D.** of the Better Living Clinic Endoscopy Center has been selected for inclusion in the 1999-2000 edition of The Nationwide Register's Who's Who in Executives and Businesses. Dr. Namihira is a native of Okinawa, Japan, and received his early education there. He began his college education at Ruyuyu University and at Ambassador College. He received his bachelor's degree from Loma Linda University and his doctor of medicine from Loma Linda's School of Medicine. He received his internal residency training in internal medicine at the Loma Linda University Medical Center. He then took a fellowship in gastroenterology at the University of Mississippi Medical Center in Jackson. He is certified by the American Board of Internal Medicine in the subspecialty of gastroenterology. He has been elected a member of the American College of Gastroenterology, American Gastroenterological Association and the American Society of Gastrointestinal Endoscopy. He received the Distinguished Service Award of Who's Who in Mississippi and was elected a fellow of the American College of Gastroenterology. He is on the staff of both ParkView Regional Medical Center and Vicksburg Medical Center.

**Richard L. Miller, M.D.** has been elected to a six-year term on the Public Employees Retirement System of Mississippi board of trustees beginning Jan. 1, 1998. The 10-member board's members include the state treasurer, two people appointed by the governor, two retirees, two state employees, and one person each from the Institutions of Higher Learning, public schools and community colleges, municipalities and counties. Dr. Miller is chief of pediatric surgery and associate dean of the University of Mississippi Medical Center.

**John Morrison, M.D.**, chairman of obstetrics and gynecology at the University of Mississippi Medical Center (UMC), has been selected to serve a second five-year term as Billy S. Guyton Distinguished Professor. The professorship carries a \$10,000 annual stipend, half of which may be used as a salary supplement with the remainder going to research related expenses such as research related travel, graduate assistantships, books, equipment, supplies and services. Originally the Barnard Distinguished Professorships, established by Chancellor R. Gerald Turner, the name was changed for the Medical Center recipients to reflect the importance of Dr. Billy S. Guyton in the history of the institution. Dr. Morrison is a graduate of the University of Memphis and holds the MD from the University of Tennessee Center for the Wealth Sciences. He completed internship and residency at UT and served in the United States Army in

Stuttgart, Germany. Medical Center faculty eligible for appointment to a Guyton Professorship must have served on the faculty for at least five years, be a tenured associate professor or professor, and if applicable, a full member of the graduate faculty, and be active in teaching and research with national distinction in one's discipline or area of study.

**Michael W. Lowry, M.D.** has relocated his Hattiesburg neurological surgery practice to 4226 Central Street, Gulfport, MS 39501.

**C. Randle Voyles, M. D.** organized a multi-disciplinary "New Energy Source Symposium" at the annual meeting of the American College of Surgeons and presented "A General Surgeon's Perspective."

**William B. Harper, D.O.**, of Greenwood, is the newest member of the state Board of Medical Licensure. Appointed by Governor Kirk Fordice to fill the unexpired term of the late Dr. Richard Peden, Dr. Harper is in the practice of family medicine.

**Claude D. Brunson, M.D.**, associate professor of anesthesiology, was elected president-elect of the Mississippi Society of Anesthesiologists at the 1998 fall meeting. **Mahesh P. Mehta, M.D.**, professor of anesthesiology, was elected secretary-treasurer, and **John H. Eichhorn, M.D.**, professor and chair of anesthesiology, was elected alternate delegate for the American Society of Anesthesiologists.

*The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.*

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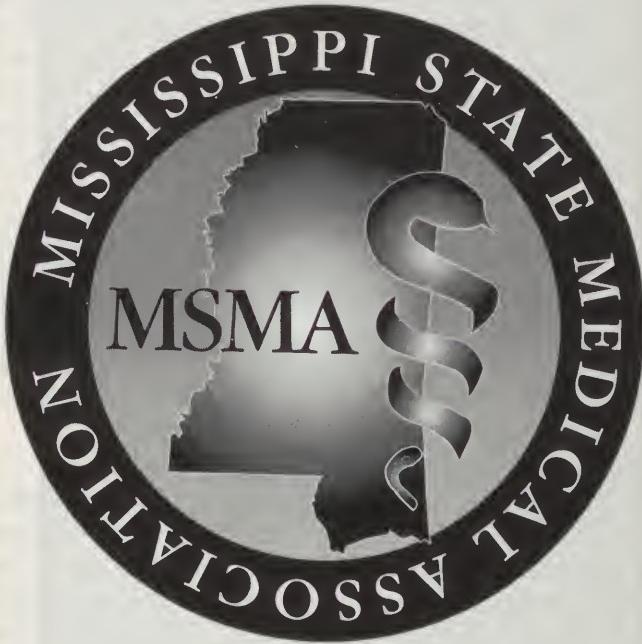
- Directing an office within the State Department of Health that has approximately 200 employees and an operating budget of approximately \$57 million.
- Planning, conducting, and supervising through subordinate staff, programs aimed at improving the health status of women, infants, and children throughout the state (maternal-child health, family planning, child health, children with special health care needs, and WIC).
- Rendering consultative services in maternal-child health matters to public officials, voluntary health agencies, committees, other professional health care providers, and various other health care organizations.
- Utilizing epidemiological and other surveillance methodologies in planning public health initiatives and consultation, in preparing reports, and in making public presentations.

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# Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

**Manuscripts** should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. **Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication.** Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

**Reviewing Process.** Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

**Title Page** should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

**Abstract**, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

**Key Words** should follow the abstract and be identified as such. Provide three to five key

words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

**Subheads** are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

**References** must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

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[1] **Author(s)**. Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] **Title of article**. Capitalize only the first letter of the first word. [3] **Name of Journal** followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] **Year of publication**; [5] **Volume number**: Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] **Inclusive page numbers**. Do not omit digits.

**Example:** Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol* 1979;71:680-692.

#### Books

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word that is not an article, preposition, or conjunction, of less than four letters. [3] **Edition number**, [4] **Editor's name**, [5] **Place of publication**, [6] **Publisher**, [7] **Year**, [8] **Inclusive page numbers**. Do not omit digits.

**Example:** DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in *Cardiovascular Medicine*, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

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**Acknowledgments** are the author's prerogative; however, acknowledgment of technicians and other remunerated personnel for carrying out routine operations or of resident physicians who merely care for patients as part of their hospital duties is discouraged. More acceptable acknowledgements include those of intellectual or professional participation. The recognition of assistance should be stated as simply as possible, without effusiveness or superlatives.

**Galley Proofs** will be mailed to the principal author for corrections. Reprint order forms will accompany galley proofs. □



**January 12, 1999 -- The Jackson Hilton**

**1:00 p.m. Welcome**

**Michael H. Carter, Jr., M.D.**

*President, Mississippi State Medical Association*

**1:10 p.m. Keynote Address**

**Honorable Tim Ford**

*Speaker, House of Representatives, State of Mississippi*

**1:30 p.m. Report from the Bi-Partisan Committee on the Future of Medicare**

*Illene Gordon, Staff Assistant to Senate Majority Leader Trent Lott*

**2:15 p.m. State Health Issues Legislative Panel**

Members of the Mississippi House of Representatives

*Honorable Charlie Capps, Chairman, Appropriations Committee: Trauma Care Network*

*Honorable Steve Holland, Chairman, Agriculture Committee: Medicaid Managed Care*

*Honorable Bobby Moody, Chairman, Public Health Committee: Health Care Trust Fund*

Members of the Mississippi Senate

*Honorable Jim Bean, Chairman, Public Health Committee: Children's Health Insurance Plan*

*Honorable Dick Hall, Chairman, Appropriations Committee: State Medicaid Reform*

*Honorable Jack Gordon, Chairman, Fees & Salaries Committee: Physicians Fee Schedule*

**3:30 p.m. Stump Speeches, Candidates for the Office of Governor, State of Mississippi**

*Honorable Mike Moore, Attorney General*

*Honorable Ronnie Musgrove, Lieutenant Governor*

*Honorable Mike Parker, former Governor*

*Honorable Charlie Williams, Chairman, House Ways & Means Committee*

*Honorable Eddie Briggs, former Lieutenant Governor*

**4:30 p.m. MSMA and MHA Legislative Initiatives**

*Charmain Thompson, Deputy Director & Director of Government Affairs, MSMA*

*Brent Alexander, Vice President for Government Relations & Communications, MHA*

.....  
Reception

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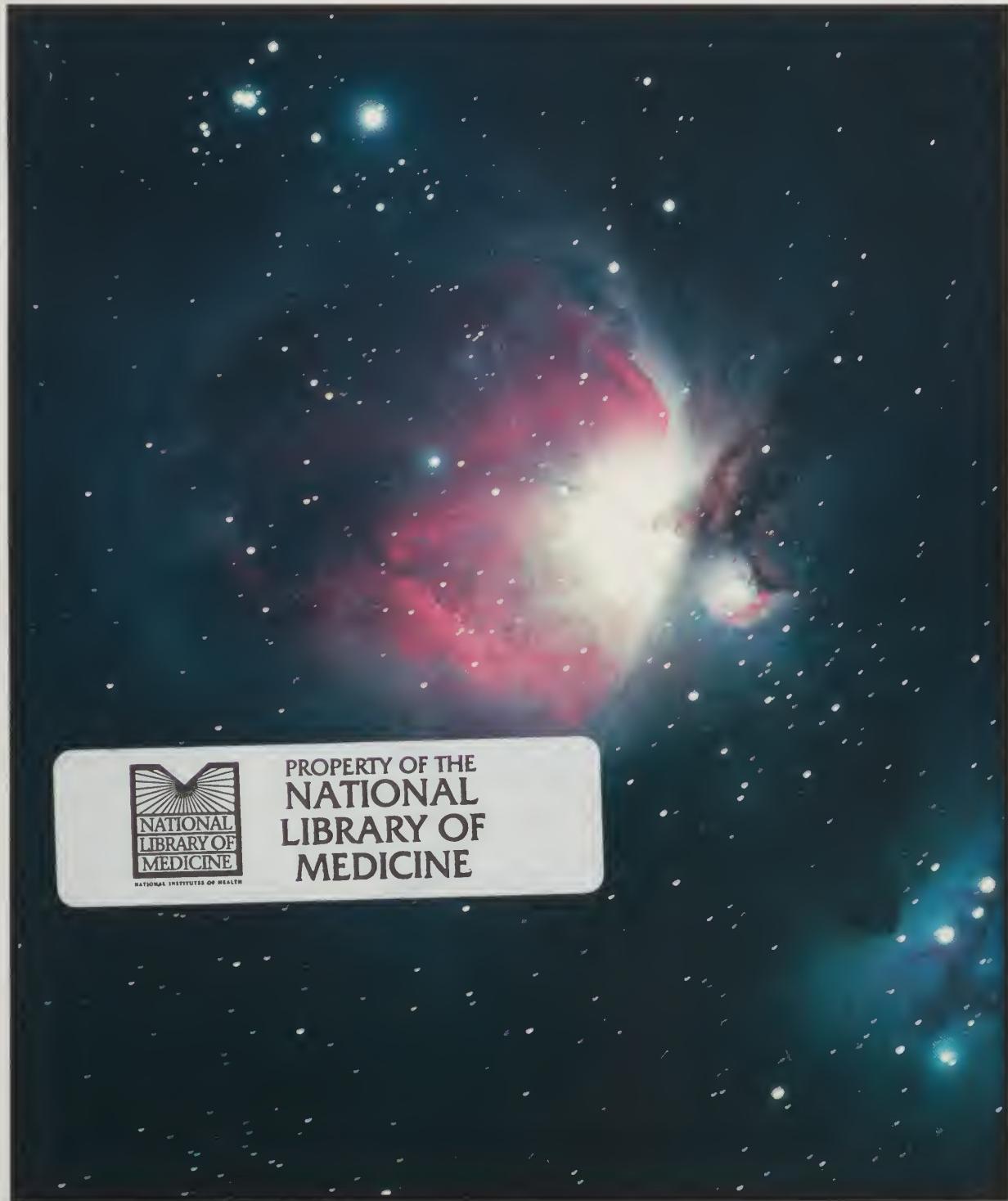
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FEBRUARY 1999

VOLUME XXXX

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## Mississippi State Medical Association

**Cover photo:** Visible to the naked eye, the Great Nebula (M42) located in the prominent winter constellation Orion glows from the hot gases of newborn stars. The photo is a 60-minute exposure taken under the dark skies of *Rainwater Observatory* at French Camp, MS. Donald P. Brannan, M.D. is an avid amateur astronomer and gastroenterologist with the Jackson Medical Clinic.

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## Amniotic Fluid Index in Normal Pregnancy: A Longitudinal Study

Suneet P. Chauhan, M.D.  
William E. Roberts, M.D.  
James N. Martin, Jr., M.D.  
Everett F. Magann, M.D.  
John C. Morrison, M.D.

### A BSTRACT

**Objective:** This longitudinal study was undertaken to characterize the change in the amniotic fluid volume in normal pregnancy.

**Methods:** Prospectively, patients with uncomplicated gestations underwent serial amniotic fluid index by a single sonographer.

**Results:** Fifty six patients underwent a total of 378 determinations of amniotic fluid volume ( $6.8 \pm 2.5$  examinations per patient). The variation in mean amniotic fluid index between 24 and  $40^{+6}$  weeks was not significantly different ( $p = 0.381$ ). Among the 42 patients who delivered at term there was no significant decrease in the amniotic fluid index between their first and last measurement ( $p=0.86$ ). However, in the 14 patients who delivered after 41 weeks, there was a significant decrease in the index over time ( $p = 0.04$ ).

**Conclusion:** The longitudinal study on amniotic fluid volume in normal pregnancy reveals that amniotic fluid index does not change significantly with gestational age.

**Key words:** amniotic fluid index, normal pregnancy

### Introduction

Due to the association of hydramnios and oligohydramnios with untoward pregnancy outcome,<sup>1-9</sup> assessment of amniotic fluid is an important aspect of obstetric examination. The amniotic fluid volume can be measured either directly by dye-dilution techniques or indirectly by sonographic examination.<sup>11-14</sup> The amniotic fluid index (AFI) is a semiquantitative measurement of the amniotic fluid volume and has become increasingly popular. Using a cross section study design, Moore and Cayle<sup>13</sup> observed, in a normal pregnancy, that AFI significantly varies with each gestational week. In contrast, Brace and Wolf,<sup>14</sup> using the dye dilution technique to determine amniotic fluid volume, concluded that amniotic fluid volume does not change significantly between 22 and 39 weeks.

The purpose of this study is to describe in a longitudinal manner how the AFI changes with pregnancy, and whether it is influenced by gestational age.

### Materials and Methods

Over a two-year period, 75 patients without pre-existing medical or obstetric complications were selected prospectively to undergo AFI measurement with their routine prenatal visits. The assessment of amniotic fluid was initiated at 24 weeks' gestation. The technique used for measuring the amniotic fluid volume has

previously been described by Phelan and coworkers.<sup>13</sup> All examinations were performed by one obstetrician (SPC) to avoid interobserver variation. The gestational age of the 75 patients was confirmed by normal last menstrual period and a sonographic examination in the first 18 weeks of pregnancy. All measurements of amniotic fluid volume were done in nonlaboring patients with intact membranes. The results of the AFI were available for clinical management.

All patients who developed oligohydramnios (AFI  $\leq 5.0$  cm) at term underwent labor induction. All patients with hydramnios (AFI  $\geq 24$  cm) were evaluated with either a one-hour glucola screen or a formal three-hour glucose tolerance test to exclude maternal gestational diabetes. In addition, a level II ultrasound examination was performed to detect congenital anomalies. Also, patients with hydramnios were offered genetic amniocentesis to exclude fetal aneuploidy.

Data was analyzed by stratifying the AFI over gestational age. Because amniotic fluid volume is not uniformly distributed, the data was transformed into logarithmic (base 10) scale for statistical analysis. The log 10 transformations were converted into their antilogs to enhance graphic display. The mean AFI value for preterm ( $< 37$  weeks), term ( $37 - 40^{+6}$ ), and postterm ( $\geq 41$  weeks) gestations were compared with analysis of variance and the Student-Newman Keul's test. The Wilcoxon signed rank test was utilized to detect difference between the first and last amniotic fluid volume. The rate of change in the AFI at successive weeks was determined by calculating the percentage change from the previous week. Polynomial regression equations were developed to describe the mean AFI between 24 and 42 weeks and the weekly percent change in the mean AFI. A value of  $p < 0.05$  was considered statistically valid.

## Results

Nineteen patients (25%) were later excluded from the study secondary to the development of a medical and/or obstetric complication. These included pregnancy-induced hypertension ( $n = 7$ ), preterm labor requiring rest and tocolytic therapy ( $n = 6$ ), preterm delivery ( $n = 2$ ), fetal macrosomia ( $n = 3$ ), and one patient with a congenital anomaly (pyloric stenosis). The mean ( $\pm$  standard deviation [SD] for maternal age in the remaining 56 patients was  $26.6 \pm 4.5$  years, while the mean gravidity and parity were  $2.1 \pm 1.2$  and  $0.6 \pm 0.8$ , respectively. Forty-nine (87%) of the patients were Caucasian with six African-Americans (11%) and one of oriental ancestry (2%). Three hundred seventy eight measurements of AFI were obtained among these 56 patients with a mean of  $6.7$

**Table 1.—The amniotic fluid index during preterm ( $< 37$  weeks), term ( $37$  to  $40^{+6}$  weeks), and postterm ( $\geq 41$  weeks) gestation.**

	Mean $\pm$ SD	Range
Preterm ( $n = 214$ )	$18.6 \pm 7.4$	6.0 - 44.6
Term ( $n = 150$ )	$17.5 \pm 9.3$	2.6 - 49.0
Postterm ( $n = 14$ )	$12.6 \pm 8.9$	4.4 - 33.9

$\pm 2.5$  examinations per patient. The mean gestational age at the first examination was  $31.2 \pm 3.6$  weeks with the first examination performed at  $39.5 \pm 1.2$  weeks.

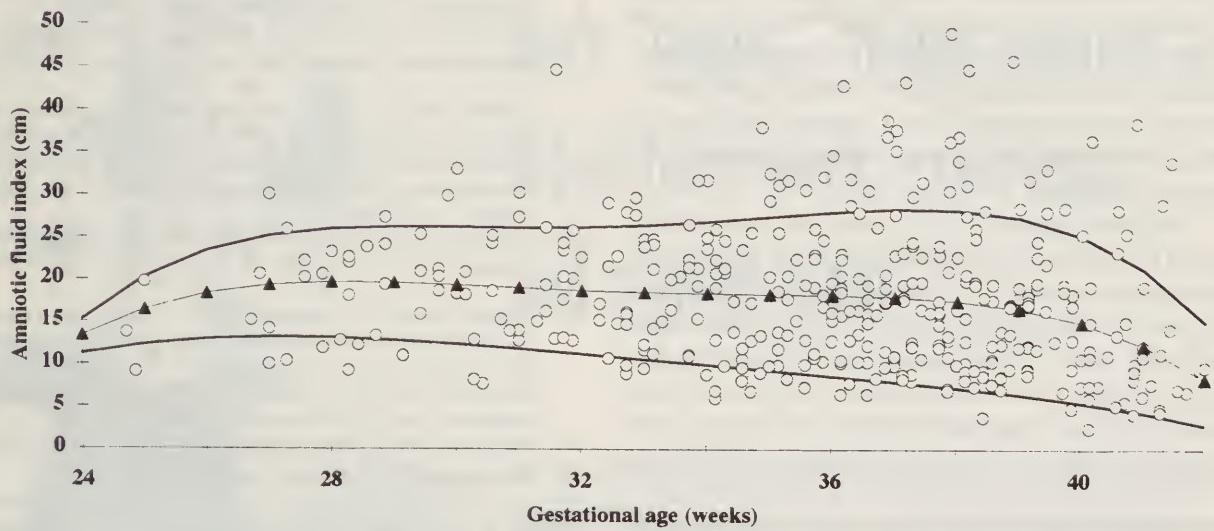
The AFI during preterm ( $< 37$  weeks), term ( $37 - 40^{+6}$  weeks), and postterm ( $\geq 41$  weeks) periods are shown in Table 1. The mean ( $\pm$  SD) AFI was  $17.9 \pm 8.4$  (range 2.5 - 49.0 cm). Analysis of variance followed by Student-Newman Keul analysis reveals that the AFI prior to 41 weeks is significantly higher than during the postterm period ( $p = 0.023$ ). However, there is no significant difference in the mean AFI between preterm and term gestations. Furthermore, among 42 patients who delivered at term there was no significant decrease in the AFI between the first and last measurement ( $p = 0.86$ ). On the other hand, among the 14 patients who delivered after 41 weeks' gestational age, there was a significant decrease in the AFI over time ( $p = 0.04$ ).

Figure 1 graphically illustrates the mean AFI from 24 - 42 weeks along with the 90% confidence intervals. The mean AFI increases slightly between 24 and 37 weeks, plateaus until 40 weeks' gestation, and then follows a steady decline.

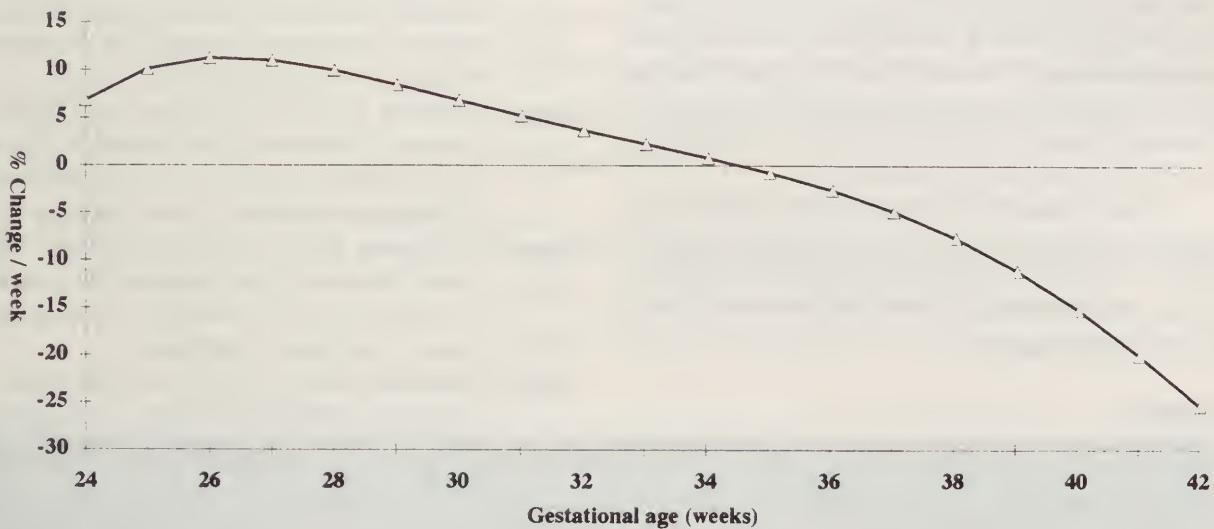
The polynomial regression equation ( $R^2 = 84\%$  and  $p < 0.0001$ ) describing the change in mean AFI per week is depicted in Figure 2. The curve has a positive slope between 24 and 26 weeks, indicating the AFI increase during this period. After 26 weeks, the slope of the curve declines crossing zero at 34 weeks. This indicates a declining rate of increase for the AFI from 26 - 34 weeks. From 34 - 42 weeks' gestation, the AFI continually decreases.

## Discussion

The AFI is a simple, semiquantitative, and reproducible method of assessing amniotic fluid volume. Hydramnios (AFI  $\geq 24$  cm) is associated with fetal chromosomal and structural abnormalities and high perinatal mortality.<sup>3,4</sup> Oligohydramnios (AFI  $\leq 5.0$  cm) is



**Fig 1.**—The mean amniotic fluid index (MAFI) from 24 to 42 weeks' gestational age (GA). The center line is the mean value, while the dotted lines are the 10th and 90th percentiles. The polynomial regression equation which describes MAFI and GA is:  $\text{Log (MAFI)} = -1967.217 + 245.70699 \cdot \text{GA} - 11.33172 \cdot \text{GA}^2 + 0.2310476 \cdot \text{GA}^3 - 0.001759 \cdot \text{GA}^4$ ;  $R^2 = 82\%$  and  $P = 0.007$ .



**Fig 2.**—Between 24 to 42 weeks, the percent change in mean AFI per week is described by the equation:  $Y = -7388.78 + 1098.58 \cdot X - 64.484 \cdot X^2 + 1.87162 \cdot X^3 - 0.02684 \cdot X^4 + 0.000152 \cdot X^5$ .

associated with a significant risk for meconium, abdominal delivery for fetal distress, and low Apgar scores.<sup>6-8</sup> Thus, it is important not only to investigate how the AFI changes with advancing gestational age, but also to predict whether a patient will develop hydramnios or oligohydramnios.

Using a cross sectional model, Moore and Cayle<sup>13</sup>

reported that the AFI is statistically different for each week of gestation. With a longitudinal design, we find that the mean AFI is not significantly different between 24 and 40<sup>+</sup>6 weeks of gestation. Only after 41 weeks of gestation is a significant difference in the AFI appreciated. Using patients as their own controls, we were unable to show a significant difference from the first to the

last AFI, provided the patient delivered before 41 weeks. Among patients who delivered at or beyond 41 weeks, there was a significant decrease in the AFI between their first and last measurement of amniotic fluid. Our findings are consistent with Brace and Wolf<sup>14</sup> who report the amniotic fluid volume, as measured with the dye-dilution technique, does not change until 39 weeks. These authors also noted that the amniotic fluid volume is not significantly different between 22 and 39 weeks' gestation and averages 777 mL.

An advantage of deriving normative data on how the AFI changes with gestational age is that it allows an investigator to generate a regression equation correlating AFI changes with gestational age. Such a mathematical model may predict which patient will subsequently develop hydramnios or oligohydramnios. We compared our equation with that generated by Moore and Cayle.<sup>13</sup> Our equation accurately predicted four of the six patients who eventually developed oligohydramnios, while their equation failed to identify any of the patients who developed oligohydramnios. Twenty five of the 56 patients had at least one AFI  $\geq 24$  cm. In 12 of these 25 patients, the hydramnios was transient (< 2 weeks) and only six patients had hydramnios for more than three weeks. Moore and Cayle's<sup>13</sup> equation correctly identified four of 25 patients who developed hydramnios, while our equation accurately predicted 18 of 25 who eventually had hydramnios (OR = 13.5, 3.4 COR < 53.6; p < 0.001). A better method to determine which equation is most predictive at extremes of the AFI would involve a population not utilized in generating either equation.

In conclusion, this longitudinal study indicates the AFI does not change until 41 weeks' gestation. Furthermore, it allows one to predict which patient would develop an abnormally high or low AFI better than previously-derived equations.

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## Legally Blind Veterans- The Link Between Appropriate Referral and the Ability to Cope

Harold L. Miller, Jr.

### I NTRODUCTION

To become blind or severely visually impaired is more than losing a primary sense. Blindness causes a complete reorganization of one's self-image in regard to physical, emotional, and psychological factors. The problems caused by sight loss can seem overwhelming. However, blindness does not have to be totally debilitating. New skills can be learned which will allow the person to again be independent. The first objective of this article is to inform health care providers about blind rehabilitation services which are available to the state's legally blind veteran population. The second objective is ask health care providers, especially ophthalmologists, to be diligent in referring those legally blind individuals to the appropriate resource. An ophthalmologist will often identify a person as being legally blind but will not use the word "blind" because of the negative connotations associated with the word; i.e. blind beggar, implying helplessness. These are images blind people combat on a daily basis. The well meaning may advise the blind person to, "go home and sit and get used to it (blindness)". This is not an appropriate way of helping the person cope with sight loss. A physician or health care provider can facilitate a person's adjustment to blindness in several ways. 1.) Be sincere. Tell the person in all honesty the prognosis of the sight loss. If the person is legally blind, tell him. 2.) Inform the patient about community, state, and federal resources or have an address or telephone number the person can call to get more information. 3.) In subsequent visits, ask if the person has taken advantage of available resources. This only takes a minute and could provide the impetus the

person may need in taking the first steps in regaining self-confidence and self-esteem.

### The G.V. (Sonny) Montgomery VA Medical Center, Visual Impairment Services Team (VIST)

At the G.V. (Sonny) Montgomery VA Medical Center, it is the responsibility of the Visual Impairment Services Team (VIST) program to identify and refer these veterans for services. There are an estimated 235,000 veterans in Mississippi.<sup>1</sup> Of this number, there will be approximately 1,080 legally blind veterans in the state by the year 2,000.<sup>2</sup> At this time, only 522 veterans have been identified as legally blind.<sup>3</sup>

VA has been a pioneer in the field of blindness since the first blind rehabilitation center was established at Hines VA Medical Center in 1948. There are currently VA blind rehabilitation centers in: Tacoma, Washington; Augusta, Georgia; Birmingham, Alabama; Hines, Illinois; Palo Alto, California; San Juan, Puerto Rico; Tucson, Arizona; Waco, Texas; and West Haven, Connecticut. Most veterans are eligible for blind rehabilitation training. To participate a veteran must be diagnosed as legally blind and meet eligibility criteria for VA healthcare. The definition of blindness states: blindness exists when best corrected central visual acuity with ordinary eyeglasses or contact lenses is 20/200 or less in the better eye, as measured by the Snellen Visual Acuity Chart; or best corrected central visual acuity is better than 20/200 but with visual field defect(s) which produces a useful visual field dimension of 20

degrees or less in the better eye.<sup>4</sup>

Approximately 85 percent of legally blind people have some useful vision; however, such tasks as reading, dressing, eating, and travelling take on a new meaning when sight loss is factored into the equation. Often people are forced into early retirement which can cause a financial strain; as a result, self-esteem and self-worth are diminished. The staff at the blind rehabilitation centers have a genuine interest in helping patients adjust to and cope with severe sight loss. Most instruction takes place in a "one-to-one" situation so that veterans can learn at their own pace.

Areas of instruction include Orientation and Mobility which allows a person to learn to travel safely and independently by using a long cane. Instruction begins with simple routes and as confidence increases so does the level of complexity. The Living Skills area is made up of Communication Skills, Activities of Daily Living, and Independent Living Program. The Communication Skills area is designed to help a person restore the ability to use written and spoken communication. This is done by instruction in typing, braille, tape recording, and telling time. Activities of Daily Living is designed to assist a person in becoming independent in such areas as washing, folding, and identifying clothing. Patients also learn such skills as organizing and preparing meals. The Independent Living Program allows patients who have mastered the various skills areas an opportunity to practice these skills before returning home.

The Manual Skills area allows patients to learn organizational skills as well as the safe and efficient use of various household tools for home maintenance. Woodworking, small motor repair, metal working, leather craft, and ceramics are also available. The Visual Skills area helps the patient maximize remaining vision, which can then be incorporated into all phases of training. Near, intermediate, and distance aids may be prescribed based on the individual goals of the patient. Recreation is also an important aspect of training. As a person's vision decreases so does their level of participation in various recreational activities. Veterans may learn various adaptive techniques for board games and card games. They may also enjoy going bowling, to museums, or to restaurants. This gives the veteran confidence in social situations which will "carry over" once they return home.

Other professionals which make up the staff are psychologists and social workers. The psychologist is available for both individual and group counselling. The social worker organizes the family program, a very important component of the blind rehabilitation program. If recommended, a family member may attend the center

for approximately one week of instruction. This usually occurs when the patient has completed approximately 3/4 of his program. The family program allows the family member to see first hand what the patient has accomplished and learns how the patient can be supported and encouraged after returning home.

While in training, each patient will be assigned a coordinator who will meet periodically with the patient to discuss progress and any specific modifications in the training program. Patients are expected to play an active role in the treatment plan. The living arrangements tend to vary from center to center, however, typically the patients are housed in a private room with two patients sharing a bathroom. The length of the training, generally four to six weeks, depends on each individual's progress. Patients should understand that to incorporate newly learned skills into one's lifestyle requires time and patience. The time invested will be time well spent.

### **The VIS Team**

The VIS Team at the G. V. (Sonny) Montgomery VA Medical Center is concerned with the welfare of each legally blind patient. Even if a blind patient does not decide to take advantage of blind rehabilitation training, they may be entitled to a yearly physical examination through the VIS Team program. In addition, the person may be referred to state services for the blind. Patients will also be informed about community services such as the Talking Book program, Radio Reading Service of Mississippi, exemption from directory assistance charges, free fishing licenses, and exemption from admission charges to state and national parks, etc.

If a person is not informed about available services and resources by the provider, then who will inform them? How can they make a decision? The relating of this information should be considered the next phase in the continuum of care. Each legally blind veteran who is referred to the VIS Team for treatment will be encouraged to continue using the referring physician for their care.

### **Conclusion**

In conclusion, it is hoped that each physician or health care provider who identifies a person as being legally blind will inform the person that they meet the criteria for blindness and then refer them to the most appropriate resource. In this way the person can begin making the adjustments needed to help them live a full and meaningful life. The VIST Coordinator can be reached by dialing the toll free telephone number 800-949-1009 ext. 1551 or (601) 364-1551.

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## Coding Concepts

**Q.** What is a compliance plan and do I need one as a small practice?

**A.** It is prudent for anyone who provides health care services and submits a claim payment to be alert to the potential for liability stemming from an inappropriately submitted claim. With the new regulations, the federal government has:

- A.** The authority to investigate the claim's propriety.
- B.** The authority to impose sanctions where an investigation finds fault with claim, ranging from a possibly inadvertent mistake to a determination that the claim was fraudulently submitted.

Health care professionals should acknowledge and pro-actively address the fee fraud enforcement environment through the establishment of a compliance plan. The purpose of a compliance plan is:

- A.** To provide evidence that any mistakes were inadvertent. This evidence would be considered in determining whether a medical practice or other health care entity has made reasonable efforts to avoid and detect misbehavior.
- B.** To detect under coding and improve communications within a practice setting.

### SEVEN ELEMENTS OF A COMPLIANCE PLAN

#### **1. A clear commitment to compliance.**

A compliance plan must ensure that everyone in the organization understands the obligation to comply with established and understood standards, and that the organization will take actions to uphold those standards.

#### **2. Appointment of a trustworthy compliance officer.**

The compliance officer will be considered to have the requisite authority if he or she is to influence behavior and organization practices.

#### **3. A routine training and education process.**

A process must be developed that will address the role of everyone involved in the organization and make participation in the compliance program understandable.

#### **4. Auditing and monitoring.**

There must be a regular review of the organization's claim development and submission process from the point where a service for a patient is initiated to the submission of a claim for payment. The monitoring process includes a methodology to facilitate employee reporting of suspected situations of fraud or abuse.

#### **5. Communications.**

Organizations must maintain an effective communications process, including a "hotline" procedure to facilitate reporting of suspected violations.

#### **6. Internal investigation and enforcement.**

Organizations must be able to conduct an appropriate investigation and take disciplinary actions.

#### **7. Response to identified offenses and application of corrective action initiatives.**

When a compliance problem has been identified, organizations have a responsibility to take demonstrable, corrective actions, including steps to prevent further similar offenses.

### DOCUMENTATION

Documentation is a central component of an effective compliance plan. Documentation must be maintained on the operation of the compliance plan.

Accurate patient record documentation is a key component of the compliance plan. Medical record information provides the justification necessary to support claims payment. The medical record may be used to validate the site of the service, the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided, and that the services have been reported accurately.

The health care community and physician practices are facing a situation where the federal government is categorizing billions of dollars worth of claims as inappropriate and possibly fraudulent. Based on a July 1997

report from the Office of Inspector General for HHS, approximately \$23 billion were overpaid in 1996 in cases involving fee-for-service payments. The report indicated that physicians accounted for 21.68% of the incorrect or improper payments. The report further indicates that 3% to more than 10% of the overpayment was attributed to health care expenditures.

As part of a compliance plan, offices should have internal and external auditing of documentation to ensure that the services billed were actually supported in the documentation. The American Medical Association suggests that offices perform audits on a quarterly basis. However, according to HCFA semiannual or annual audits should be sufficient to adhere to a compliance program.

#### CODING TIP

To protect your practice, know the law and the rules. Take steps to be sure your documentation supports

the levels of services billed to the insurance company.

*Do you have a question you would like answered in the Journal? Send your inquiries to Wanda L. Adams, CPC, Adams & Associates, 3201 Cambridge Drive, Festus, MO 63028. Please include your name and phone number should additional information be required.*

*Wanda L. Adams, CPC, is owner and president of Adams & Associates, a health care consulting firm. She is a senior health care consultant and published author. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.*

*CPT codes and descriptions, copyright 1998, American Medical Association.*

## WHEN YOU NEED TO BE SEVERAL PLACES AT ONCE, ISN'T IT A RELIEF TO KNOW YOUR BANK WILL BE THERE, TOO?

The frantic pace of everyday life doesn't leave a lot of time to get to the bank. No problem... if you rely on the convenience of one of the state's largest banking networks. Trustmark has more locations in the places where you need us most. We have Trustmark Express ATMs throughout the state. And 130,000 ATMs around the world through our GulfNet and CIRRUS® affiliations. Plus, Trustmark's Express Check debit card gives you purchasing power wherever MasterCard® is accepted, letting you pay by check without writing one. So, next time you're worried about getting to the bank, relax. Whether you're headed ACROSS TOWN or ACROSS THE STATE, there's one bank you can trust to be there: TRUSTMARK.



Member FDIC



## **Seeking Nominations for the 1999 MSMA Award for Community Service**

The **Annual Physician Award for Community Service**, sponsored by Mississippi State Medical Association, is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

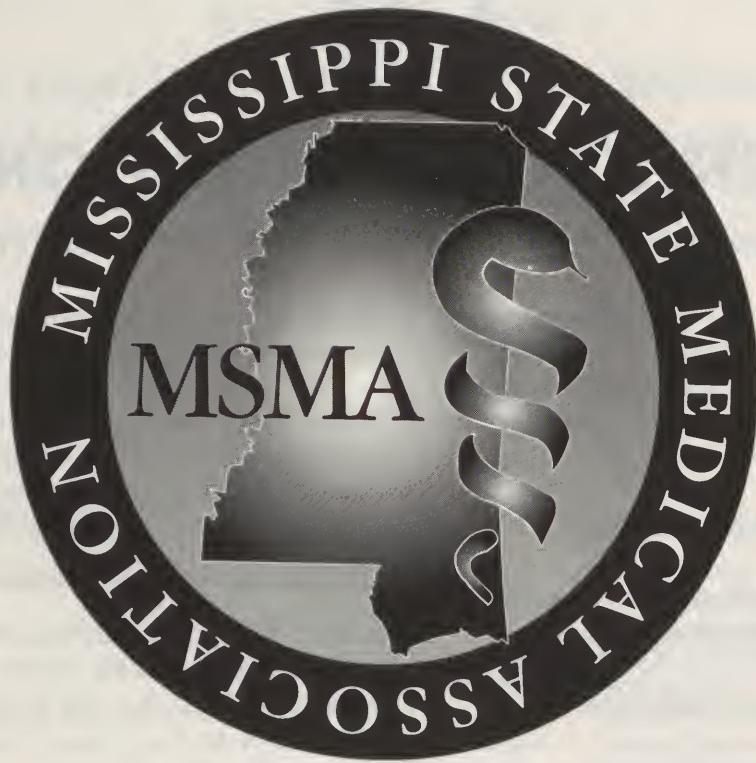
**Each recipient of the award is nominated by his or her component society** and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. All nominations should be submitted to the Mississippi State Medical Association by February 12, 1999.

**The award is a handsome plaque** which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A \$500 contribution** is also made by the association to a civic organization designated by the award recipient.

**Nominations should be submitted in writing.** There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

**Nomination supporting documents may include all or some of the following:** a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

**Nominations should be sent to MSMA**, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 12, 1999. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.



**131ST  
ANNUAL SESSION  
&  
SCIENTIFIC ASSEMBLY  
PRELIMINARY PROGRAM**

**May 14 - 16, 1999  
Grand Hotel & Resort, Biloxi, MS**

Supplement to The Journal of The Mississippi State Medical Association, February 1999



# GENERAL INFORMATION

## REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in all references committees as policies of the Association are established. All meetings will be held consecutively.

### The Schedule is as follows:

- |         |  |
|---------|--|
| 2:00 PM | <b>MSMA Reference Committee on Constitution and Bylaws</b> |
| 2:30 PM | <b>Reference Committee A</b>                               |
| 4:00 PM | <b>Reference Committee B</b>                               |

## CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours for this session will be listed in the official program of the 131st Annual Session.

## MSMA ALLIANCE PROGRAM

The MSMA Alliance will hold its 76th Annual Session Meeting, May 14-16, at the Grand Hotel & Resort. A copy of the meeting agenda is enclosed with the Distaff.

Members and their spouses are invited to all social events which are all complimentary except the MSMA / MSMA Alliance membership reception and dinner featuring the Sotiles.

## THE PRESIDENT'S RECEPTION

The annual **President's Reception** will be held Friday evening, May 14, in the Ballroom of the Grand Bayview Hotel in Biloxi, from 6:30 PM to 8:00 PM. Tickets will be provided for a live performance in the Grand Theatre, which is adjacent to the hotel, following the reception. However, the name of the show has not been announced at this time.

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## MSMA/ MSMA ALLIANCE MEMBERSHIP PARTY TO FEATURE GUEST SPEAKERS WAYNE SOTILE, PH.D. AND MARY SOTILE, M.A.

The **MSMA/MSMA Alliance Membership Cocktail Reception and Dinner** will be held on Saturday evening, May 15, at 6:30 PM in the Grand Bayview Ballroom. An added attraction will be guest speakers Wayne Sotile, Ph.D. and his wife, Mary, co-authors of the groundbreaking book, *The Medical Marriage: A Couple's Survival Guide*, a fast-paced, humorous and compassionate look at the unique challenges that face today's physicians and their loved ones. The Sotiles will speak on "Managing the Stress of Medicine and Personal Relationships." Based on their experiences counseling over 600 physicians and their families, the Sotiles offer practical ways to maintain stress resilience as a medical family and enjoy each other in the process. Admission tickets will be available for \$25.00 per person to offset the costs for these nationally recognized speakers. The MSMA Alliance will once again hold a silent auction with proceeds benefiting the AMA Foundation. Association members and guests will have the opportunity to browse through the items for auction and make their silent bid before dinner. All items will be sold before the conclusion of the party.

# MSMA 131st Annual Session and Scientific Assembly

May 13-16, 1999

Grand Hotel Resort • Biloxi, MS • 1-800-354-2450

Deadline for Guaranteed Reservations: April 15, 1999

## PRELIMINARY SCHEDULE

### THURSDAY, MAY 13

1:00 p.m.	Exhibitor set-up Registration
1:00-4:30 p.m.	AMA Communications Media/Speakers Training-Pat Clark
4:30 p.m.	Board of Trustees Meeting

### FRIDAY, MAY 14

7:30 a.m.	Continental Breakfast with Exhibitors Specialty Society Breakfast: Mississippi Section of the American College of Obstetricians and Gynecologists
8:00 a.m.	Registration Reference Committee Meeting/Breakfast
9:00 a.m.	House of Delegates
11:00 a.m.	Lunch with Exhibitors
12 noon	Board of Trustees Meeting Alliance Pre-Convention Lunch Meeting YPS Business Meeting MMPAC Board of Directors Meeting
12:30 p.m.	Cooperative Actions for Health Program (CAHP) / Medicine Public Health Initiative Program MPIC Stockholders Meeting Reference Committee on Constitution and Bylaws
2:00 p.m.	Reference Committee A Reference Committee B
2:30 p.m.	President's Reception
4:00 p.m.	Casino Show (if available)
6:30 p.m.	Southern Medical Association Coffee and Dessert Party
8:00 p.m.	
9:30 p.m.	

### SATURDAY, MAY 15

7:30 a.m.	Registration Continental Breakfast with Exhibitors Board of Trustees Meeting Specialty Society Breakfasts: MS Chapter of the American College of Surgeons Breakfast Mississippi Society of Anesthesiologists Breakfast
8:30 a.m.	Past President's Breakfast Fifty-Year Club Breakfast Plenary Session
9:00 a.m.	Alliance Welcome and Coffee
11:30 a.m.	Alliance House of Delegates Meeting Alliance Luncheon Specialty Luncheons: MS Academy of Family Physicians MS Chapter of the American College of Surgeons
12:00 p.m.	MS Society of Anesthesiologists MS Neurological Association
1:00 p.m.	Plenary Session
4:00 p.m.	Component Society Caucuses
5:30 p.m.	Alumni Receptions
6:30 p.m.	MSMA/MSMA Alliance Membership Cocktail Reception, Dinner and Silent Auction (Dinner speakers: Wayne Sotile, Ph.D. and Mary O. Sotile, M.A.-“Survival Guide for the Medical Marriage”)

### SUNDAY, MAY 16

7:00 a.m.	Board of Trustees Meeting Continental Breakfast for Members
7:30 a.m.	Alliance Past-Presidents' Breakfast
8:00 a.m.	Worship Services
9:00 a.m.	House of Delegates
12 noon	Board of Trustees Meeting and Lunch Mississippi Association of Pathologists Meeting and Lunch (12-3:00 p.m.)

# **"MEDICAL PRACTICE IN A HIGH IMPACT SOCIETY" EDUCATIONAL PROGRAM**

(PRELIMINARY SCHEDULE)

## **PLENARY SESSION**

SATURDAY, MAY 15 • OASIS BALLROOM

8:30 A.M. **PANEL: "THE TREATMENT OF CHRONIC AND INTRACTABLE PAIN"**

•**CLINICAL PERSPECTIVE**

C. Anne Myers, M.D., Director

The Pain Clinic, Jackson, Mississippi

•**REGULATORY PERSPECTIVE**

W. Joseph Burnett, M.D., Executive Officer,

Mississippi State Board of Medical Licensure

9:45 A.M. **"SPORTS MEDICINE UPDATE"**

William B. Geissler, M.D., Associate Professor,

University of Mississippi School of Medicine

Department of Orthopedic Surgery

10:30 A.M. **"BUILDING A STATEWIDE TRAUMA SYSTEM IN MISSISSIPPI"**

•**PROGRESS REPORT**

Ed Thompson, M.D., State Public Health Officer

Mississippi State Department of Health

•**ESSENTIAL COMPONENTS FOR HOSPITALS AND MEDICAL STAFFS**

Frank Ehrlich, M.D., Chairman

Department of Surgery, St. Joseph's Hospital

Patterson, New Jersey

11:30 A.M. **LUNCH BREAK**

1:00 A.M. **"UPDATE ON ORGAN TRANSPLANTATION"**

- Sponsored by Mississippi Organ Recovery Agency (MORA)

•**A RECIPIENT'S PERSPECTIVE**

Phil Berry, Jr., M.D., President,

Texas Medical Association

•**THE MISSISSIPPI ORGAN RECOVERY AGENCY (MORA)**

Shirley D. Schlessinger, M.D., Assistant Professor

University of Mississippi School of Medicine

Department of Internal Medicine

2:30 P.M. **"RISK MANAGEMENT"** - Sponsored by MACM

(Speaker unconfirmed at press time, to be announced in next program)

3:15 P.M. **"HEALTH CARE LEGISLATION AND THE 106TH CONGRESS"**

Julius Hobson, Director of Congressional Affairs

American Medical Association

4:00 P.M. **ADJOURN**

**PLENARY PROGRAMS PLANNED BY MSMA's:**

**COUNCIL ON SCIENTIFIC ASSEMBLY**



# Mississippi State Medical Association Alliance

76th Annual Session  
May 13-16, 1999  
Grand Hotel & Resort  
Biloxi, MS

## THURSDAY, MAY 13

1:00 AM - 4:00 PM      Registration - 2nd Level

## FRIDAY, MAY 14

8:00 AM - NOON      Registration - 2nd Level  
12:00 PM      Pre-convention Board Meeting/Luncheon  
6:30 PM      MSMA President's Reception

## SATURDAY, MAY 15

8:30 AM      Alliance Welcome and Coffee  
9:00 AM      House of Delegates  
11:30 AM      Luncheon/ Installation of Officers  
1:00 PM - 5:00 PM      View AMA-ERF Auction items  
2:00 PM      Post-convention Board Meeting  
6:30 PM      MSMA/ MSMAA Membership Cocktail Reception, Dinner  
& AMA Foundation Auction (Dinner speakers: Wayne Sotile,  
Ph.D. and Mary O. Sotile, M.A.-“Survival Guide for the  
Medical Marriage”)

## SUNDAY, MAY 16

7:30 AM      MSMAA Past Presidents' Breakfast

# **Mississippi State Board of Medical Licensure**

## **Annual Report for the Period July 1, 1997 through June 30, 1998**

The Mississippi State Board of Medical Licensure is the State's legally constituted licensure Board for medical doctors (MDs), osteopathic doctors (DOs), and podiatrists (DPMs). The Board is responsible for setting policies and professional standards regarding the practice of medicine and pediatric medicine; considering applications for licensure; conducting licensure interviews; investigating legitimate drug traffic among medical practitioners under the State's Uniform Controlled Substances Act; conducting hearings on disciplinary matters involving violations of the State's Medical Practice Act; and keeping up-to-date records on all licensed physicians, osteopathic physicians and podiatrists in the State.

The Board is composed of nine physicians (8 MDs and 1 DO) appointed by the Governor, and meets bimonthly on the third Thursday beginning in January of each year.

The administrative functions of the Board are performed under the direction of its Executive Director, W. Joseph Burnett, M.D. Seventeen full-time staff members consist of: two division directors; six investigators; two licensing officers, professional; one accountant; one programmer analyst, II; one administrative assistant VI; one administrative assistant V; one projects officer, III; one secretary executive; and one secretary. The office of the Board is located at 2600 Insurance Center Drive, Suite 200B, Jackson, Mississippi 39216.

### **LICENSURE DIVISION**

Any physician, osteopathic physician, or podiatrist desiring to practice medicine in Mississippi must first obtain a license to do so by contacting the Board. When an inquiry concerning licensure is received, an application packet is mailed to the practitioner. Based upon the information given by the practitioner, a determination is made as to his/her eligibility for licensure. Queries are made to the American Medical, Osteopathic, or Pediatric Medical Associations; other states in which the practitioner is or has been licensed; National Practitioners Data

Bank; Federation of State Medical Boards; and hospitals where the practitioner holds or has held staff privileges. Upon completion of required information, the applicant is scheduled for a personal interview and the issuance of his/her Mississippi medical license. This process takes from four (4) to six (6) weeks.

During the year ending June 30, 1998, one thousand nineteen (1,019) NEW licenses were issued. It is significant to note that during the last three (3) years, the Board has experienced an INCREASE of eighty per cent (80%) in new licenses issued. With the increase in new licenses issued, other areas of the licensure program performance indicators and measures are increased, i.e., applications for licensure mailed and processed, written verification of licensure to other states and regulatory boards, and annual renewal applications mailed and processed.

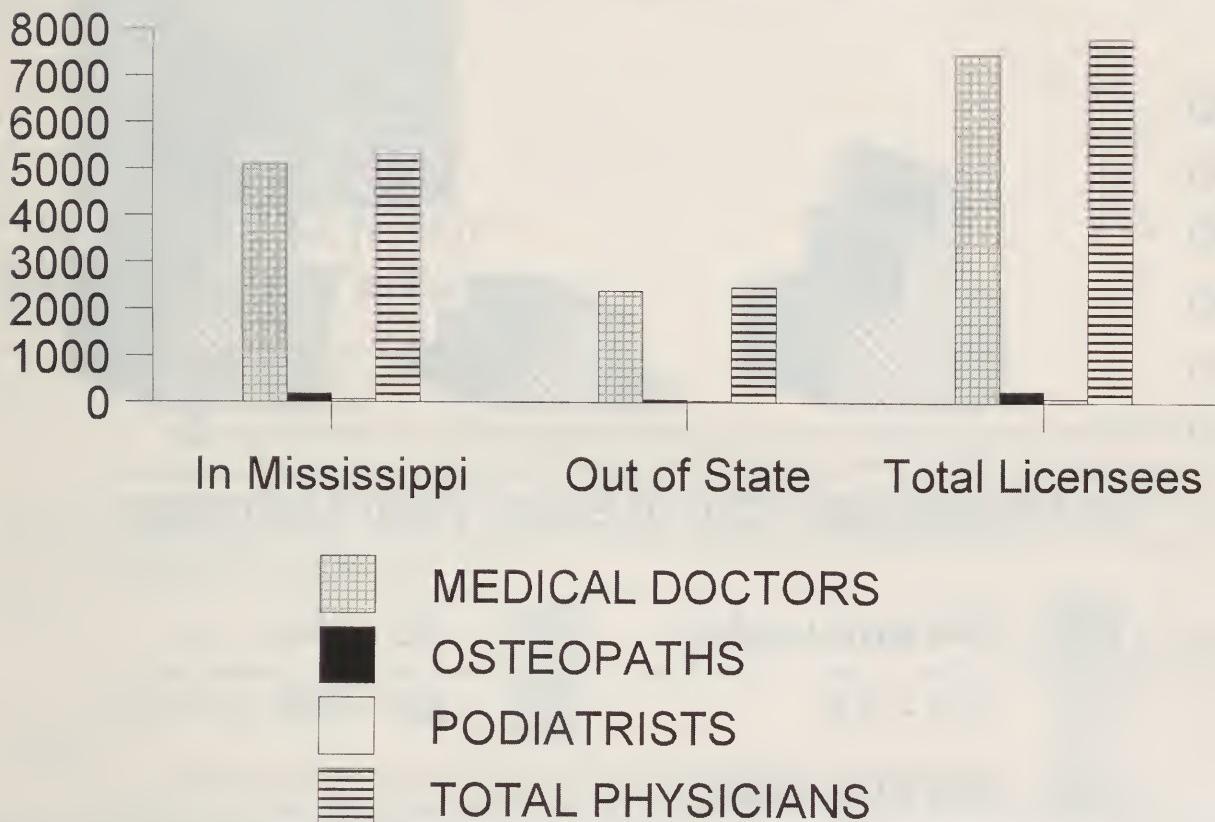
During the fiscal year ending June 30, 1998, the Board processed seven thousand,eight hundred seventeen (7,817) annual renewals for Mississippi licenses.

In compliance with House Bill 1147, the Licensure Division implemented the tracking of continuing education requirements for radiologic technologists and others employed in a physician's office who perform x-rays under the specific direction of a physician. Radiation technologist permits have been issued to those individuals whose certification of completion of the required courses have been forwarded to the Board of Medical Licensure. This requirement is an on-going process of the Licensure Division. During the fiscal year ending June 30, 1998, the Board has issued five hundred-fifty radiation technologist permits.

In compliance with Senate Bill 2070, the Board of Medical Licensure has entered into a Memorandum of Understanding with the Mississippi Department of Human Services to track and report to them the names of licensees licensed by this Board in order to assist in tracking professional licensees who are delinquent in child support. An updated report is presented to the Department

# ACTIVE PHYSICIANS

FY98 JUNE 30



of Health and Human Services on a monthly basis, or more often if requested to do so.

The Licensure Division responds to thousands of telephone calls each year from the public as well as other licensing/regulatory agencies regarding the status of a physician's license. The Licensure Division submits certified documentation physician, and responds to requests for laws, rules and regulations pertaining to physicians in this state. The Licensure Division is responsible for filing all rules and regulations of the Board with the office of the Secretary of State in compliance with the Administrative Procedures Act and issues a printed copy of the laws, rules and regulations governing the practice of physicians to all new licensees at the time of their interview for licensure.

## INVESTIGATIVE DIVISION

Under the direction of the Executive Director, the Board's chief investigator and six investigators carry out the responsibilities of investigating alleged violations of the Medical Practice Act and the Mississippi Uniform

Controlled Substances Act as it applies to medical practitioners.

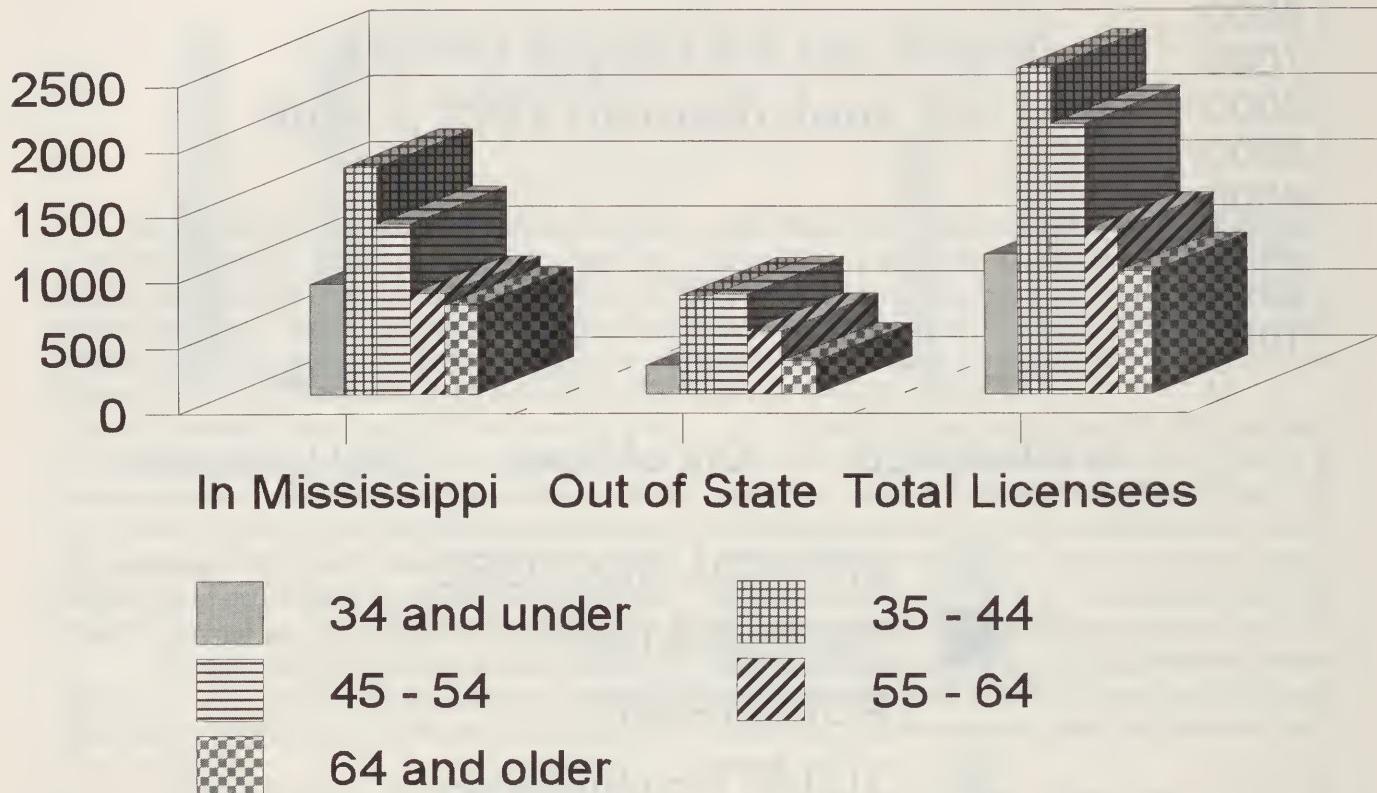
The Investigative Division is responsible for conducting pharmacy profiles. These profiles are designed to determine if a physician is prescribing an unusually large quantity of drugs to a particular patient, if a patient is going from one physician to another for the same or similar drugs, or if the licensee is obtaining controlled substances for personal use.

In addition to pharmacy profiles, the investigators are responsible for looking into all substantial complaints received concerning a physician and monitoring compliance with existing Board disciplinary orders. These investigations may include the screening of the physician for drug use, sexual boundary violations, or competency questions.

During the year ending June 30, 1998, the Investigative Division processed three hundred twenty-five (325) complaints/practitioner intelligence reports; worked one hundred one (101) investigations; and took forty-eight

# ACTIVE PHYSICIANS

## BY AGE



(48) disciplinary actions.

During the fiscal year ending June 30, 1998, the Investigative Division completed one phase of its decentralization project by placing an investigator in Oxford, Mississippi. A second phase of decentralization is in the planning stage for the Gulfport/Hattiesburg, Mississippi area. It is anticipated that the Gulfport/Hattiesburg office will become operational in FY99. The purpose of this project is to provide better and faster response to problems in the areas of the state located long distances from the Jackson office, as well as reduce travel costs.

Included with and attached to this Annual Report is a report of the FY98 Income and Expenses for the Board of Medical Licensure. All income is derived from fees collected for the annual renewal of physicians' licenses, applications for licensure, USMLE Step 3 licensure examination, SPEX (Special Purpose Examination for assessment of current competence, requisite for the general, undifferentiated medical practice by physicians), certification of license to other states, copy costs and various

small fees relating to licensure. Expenses are shown for major object codes as reflected on budget request for fiscal year ending June 30, 1998.

### MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE FY98 INCOME AND EXPENSES

<b>INCOME:</b>	\$1,226,234
<hr/>	
<b>EXPENSES:</b>	
Personal Services	\$ 629,744
Travel	28,382
Contractual	342,328
Commodities	39,624
Capital Outlay	80,941
Subsidies, Loans & Grants	10
<b>Total Expenditures</b>	<b>\$1,121,029</b>
<b>Cash Balance - Unencumbered</b>	<b>\$1,636,553</b>
	\$2,862,787
<b>Less: Estimated Cash Available</b>	<b>(1,741,758)</b>
<b>TOTAL</b>	<b>\$1,121,029</b>
	<b>\$1,121,029</b>



## Preaching to the Choir

**Michael H. Carter, Jr., M.D.  
The President's Page**

**T**here is a growing number of Mississippi physicians who see the value of joining MSMA. The association's membership increased by more than 250 members in 1997 and 1998. This is not the case in other states. Since 1997 membership in state medical associations has declined from 73 percent to 47 percent across the country. County medical societies have also suffered a decline in membership, from 67 percent to 43 of market share.

I ask myself why this is happening. Who, besides organized medicine, is looking out for the interest of physicians and our patients? It is certainly not the federal government, state government, or least of all the managed care industry.

Sometimes you hear doctors say they don't belong to organized medicine because membership is too expensive. Some say the drastic decline in reimbursements for our services is making this hurdle even higher. But the truth of the matter is that we simply can't afford not to belong.

For example, it was MSMA that stepped up to the plate and challenged Medicaid's elimination of the cross-over payment for dual eligibles this past summer. Without MSMA to alert members, negotiate with legislators and Medicaid officials, we'd all be getting 20 percent less than we do now for seeing those patients. MSMA's still at it during this present legislative session battling for a new Medicaid fee schedule, funding for the State Children's Insurance Plan, and activation of the Trauma Care Network.

There's just no telling how much physicians' scope of practice would be eroded by now if MSMA had not been there fighting the good fight to prevent non-physicians from prescribing drugs, performing surgery, and practicing medicine. At the state Capitol, in the halls of Congress and around the board table of the myriad of state agencies that regulate health care, MSMA looks out for the best interest of medicine. Think, too, of what you can save in storage, insurance premiums and out-of-pocket expenses now that MSMA passed the 7-year statute of repose on medical malpractice cases last year.

This should be enough to convince every physician that we just can't afford not to belong to organized medicine. I know I'm preaching to the choir, but I'm working to make the choir bigger. I'm asking you, too, to be an emissary for MSMA. Think about the Medicaid debacle this summer, scope of practice infringements on our patient base, and the successful tort reform bill. It seems to me that membership in organized medicine has been an investment that I can't afford to pass up.

A handwritten signature in cursive ink that reads "Mike Carter".

# Editorials

JOURNAL OF THE  
MISSISSIPPI STATE MEDICAL ASSOCIATION  
VOLUME XXXX, NUMBER 2  
FEBRUARY 1999

## WALL STREET THROWS IN A TOWEL

Some of you careful observers of the stock markets may have noticed something recently. No, I'm not speaking of the high flying internet stocks; I'm speaking of the carnage among the physician practice management companies. Companies such as Med Partners, Phycom, and Coastal Physicians Group have seen plunges of 50 to 99% during the past year in prices of their stock. These were the companies that were supposed to organize us, buy us, show us what efficiency was all about and give us negotiating clout vis-a-vis the HMO's. Now they join the building trash pile composed of the likes of Columbia/HCA and Humana.

These companies were the darlings of investors, and I know Wall Street is supposed to know, but does anyone know, really know, what a clinical encounter is? Of course not, except for us. The vast majority of encounters are good, we know that. In these encounters insight is passed, either by the doctor to the patient, or by the patient to the doctor. Healing thereby occurs. Time in the examining room has little to do with it. An eyebrow raised or an incisive comment made at a telling moment may be the difference between life and death for an individual patient. And just as time bears little on the matter, neither do bullets or unshaded boxes or twelve elements in the physical exam rather than six. All of which is another way of saying that these companies and the investors who support them know nothing of what they're talking about.

To them an office visit is an office visit, the same except for the number of bullets and elements. Then the visit becomes something Wall Street or the government can understand, a commodity. Then it becomes like a barrel of oil, each virtually the same, and subject to bids and contracts and futures.

Well, I guess these physician management companies have learned some lessons. Things aren't quite so clear as they had supposed. However, we are still left with business behemoths in our midst. New ones rise to replace the old, and new concepts emerge on how to turn an office visit into a commodity. Our crying need as doctors is a way to address these organizations collectively at a bargaining table. Physician management companies were supposed to be a way to negotiate, but only became part of the problem. We as organized medicine have also grappled with the problem, but so far haven't found a way to move in a unified effort given the present antitrust environment. We know the clinical encounter and are uniquely disposed to represent our interests. How we respond to the problem will largely determine the future Value of the AMA and the MSMA to the individual practicing doctor.

—Leslie E. England  
Associate Editor

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

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## NANCY'S GIFT

Monday, November 23 - 9:30 a.m.

Clinic Intercom: "Dr. South, there's a Dr. Tatum for you on line 2."

NT: "Good morning, Wally. I didn't get you away from a patient did I?"

DS: "Hey, Nancy-Bell!! What's going on girl?"

NT: "I'm calling about the board meeting on the 12th. Ya'll were still planning on spending the weekend with us weren't you?"

DS: "Sure... if the invite is still open."

NT. "It is ..... but I have to tell you about something that's come up. I'm going to have a little surgery tomorrow morning..."

DS: "Don't tell me, let me guess - You're not having a hysterectomy like every other woman our age are you?"

NT: "I wish. No ... well ... for the past several weeks I've been feeling rough, you know, hurting in my neck and arms, so I was thinking maybe I had a ruptured cervical disc. I went over and got a CT on my neck, but that turned out fine. Then for the past couple of weeks or so I've been swelling in my face and arms 'til I looked like the 'Pillsbury Dough Boy.' I thought maybe it was some weird allergy, but I finally broke down and went to see the doctor 'like we're supposed to.' Do you know Diane Ferguson? Well, anyway, she ordered studies on my chest and they found this ... this big old mass in my mediastinum ..."

DS: (Interrupting) "Oh, my God, Nancy - what do they think it is?"

NT: "Whoa - let me tell you - the bottom line is - we don't know. But everybody has their theories. Thymoma ... Teratoma ... Lymphoma ... Last week was a really bad one for me, a real bummer. Dr. Varner down at Methodist in Hattiesburg scoped me and took some tissue samples which were inconclusive for anything. But he recommends immediate surgery to relieve my superior vena cava syndrome. Tommy Rueff is going to do it first thing in the morning at Baptist in Jackson."

The gravity of Nancy's situation settled in to my hyperactive Monday morning psyche. I remember uttering a string of curse words which I shall not repeat here and immediately losing my composure, which I'm not apt to do, especially with Nancy. She doesn't like that. But her predicament and her bravery combined with an ominous foreboding reduced me to tears on the phone. Nancy went on-

NT: Now, straighten up, Wally, everything is going to be alright. We'll just have chest tubes in ICU for Thanksgiving instead of turkey and dressing. The really sad part is going to be missing that AMA delegation trip to Hawaii Saturday. Bill Roberts may have to get me a rain check on that one ... But you be sure and plan to come on to the house on the 12th because by then I'll be feeling well enough to have company and I'll need some comic relief. Maybe we can get George and Hilda McGee over for a pallet party."

DS: "Nancy - you can't mean it!"

NT: "I'm serious, What's your fax number and I'll send you a map to my house later this afternoon. I'm going in to work and tie up a few loose ends first."

I gave her the number and told her I'd be in touch constantly over the next few days and that from this distance all I could do to help was pray ... a lot. And Nancy said that was all she needed for me to do right then.

After the phone call I tried to sublimate my fears for her throughout the day, In the midst of thoughts of how to best approach this particular patient's migraines or manage that one's chronic stasis dermatitis, my thoughts were of Nancy, of how she must be feeling that day and what she had to face.

\*\*\*

Nancy Tatum and I became friends 22 years ago as freshmen med students. The medical school experience has a way of bonding folks as all intense situations are wont to do. From the beginning Nancy was so much more "together" than the rest of our bunch. She had a few years on us and had already been out in the real world, making a living teaching school prior to coming to UMC.

One thing we had in common was striking out for home at every opportunity. I don't know who was the worst homebody, Nancy or me. On Fridays, whenever the last textbook snapped shut or the last admission was worked up, she would get in her buggy and head south to Hattiesburg lickety-split, and I would head northeast to the Hatchie Hills. I recall once calculating how many hours we spent on the highway during those four years and how crazy that was, and how much anatomy and pharmacology we could have learned in those hours if we'd been smart, but how twenty years later we'd do it all over again in a heartbeat if given the chance.

And when schooling was all said and done Nancy went home again to do Family Medicine with her dad in Petal, and I came to roost at home in Ripley. During those years we didn't see much of each other, but I remember her telling me once how she thought her dad was trying to starve her to death. Said she figured she'd been making something like minimum wage when you considered the hours and that Dr. "A.T." still thought he was overpaying her. And the "worst thing is, we do all this work and daddy won't even let us send our statements!"

\*\*\*

Tuesday morning came and time for her surgery. I still carried that heavy sense of dread that morning. Couldn't make myself feel as hopeful as Nancy had wanted me to be, Calling a few times to check later in the day I was able to talk with Nancy's dearest friend Anne McWilliams about her progress. The surgery had been complicated and lengthy. The hoped-for easily shelled-out thymoma was not be found, but rather a "horrendous unidentifiable mass of fibrous invasive tissue wrapped around every vessel and pipe in her anterior superior mediastinum." There was involvement of the pericardium and pleura. The lumen of the superior vena cava was reduced to a thready ribbon nearly totally occluded by the adhesions. A golf-ball sized quantity of lymphomatous tissue was unresectable.

Anne and the family were at that point in the afternoon marking Nancy's apparent good progress in post-op recovery and awaiting a final tissue diagnosis on the now obvious malignancy so that a course of radiation or chemotherapy could be outlined.

Hearing what I thought then to be the worst possible news I began to think of what we could do to raise Nancy's spirits when the board meeting convened in Jackson in two weeks. My brainstorm was for the group to carpool out to her house and serenade her with Christmas carols and perhaps the requisite wassail.

Along with many others I was thrilled that Nancy was serving on the MSMA board. We'd had only one meeting since the election and being new kids on the block neither of us vocalized much that weekend. Time for just figuring out what the heck we were doing there. I recall remarking to Nancy that we were like two dogs chasing a car tire and now that we'd caught it, didn't quite know what to do with the darn thing. She got a kick out of that.

Later that evening, I recalled the voting day at annual session when the election for her post went to a tie-breaking ballot, not once, but twice. I watched Nancy during that nail-biter and the woman never batted an eye. Oh, if only to be so totally cool as Nancy Tatum!

When I phoned her at work the following week to congratulate her once again, her grace and equanimity still shone through. She remarked, "You know it really didn't matter who won that election, my opponent is a good guy and he would have done a fine job on the board."

Somehow this struck me as a typical "Tatum-ism."

\*\*\*

Then around 10 p.m. on the night of November 24<sup>th</sup> I called the family room once again to check on Nancy. Anne, being completely unaware of the dramatic turn of events transpiring in the ICU even as we spoke, gave me a satisfactory progress report.

It was not until mid-Wednesday morning that I was to learn of the disastrous night that had befallen Nancy.

If anyone is exactly certain what patho-physiologic set of circumstances led to her crashing that night, I have not heard it. Dr. Lessa Phillips described for me the helplessness everyone felt when Nancy "coded" and absolutely nothing could be done to alter the heart-wrenching downward spiral.

She remained in a coma through the night sustained of course only by mechanical means. Her EEG and flow studies showed no brain activity. Nancy, consistent with her concern for end-of-life-issues and her total preparation for every situation, had left an advance directive. By her request, in this most hopeless of situations, the life support systems were discontinued shortly after 3 p.m., Wednesday, November 25. The end came with merciful swiftness around 3:30 p.m.

\*\*\*

I kept on seeing patients that afternoon in the clinic because that's what Nancy would have done. But it is especially hard to listen to people whine about their sinuses and low back pain when one of your dearest friends has just died.

So, I whistled so that I would not weep...

On arriving home from clinic a couple of hours later I checked my mail and discovered that Nancy had sent me a beautiful hand-written note card. May I share the text?

"Dear Dwalia,

11/23/98

So sorry to blow your mind so early on a Monday morning! But I did want to talk with you myself and let you know what's happening. It has been a tremendous shock to my system both physically and psychologically. Overall, I feel much at peace with the plan. The uncertainty is a bit unnerving, but when is that not the case!??!

Here's the map- come on down- it gives me something to look forward to! Take care and know I love you and treasure your friendship.

Nancy"

and a wonderful map to her home was enclosed ....

I was galvanized by her posthumous correspondence. I carried this sweet gift with me for days, showing it to folks, until I've near worn it out. That note was one of the "loose ends" that Nancy took care of at the clinic the day before her surgery. She even caught up on all her chart dictation, something that I'm afraid would not have been a priority item for post of us.

Unable to sleep much because of the steroids and the general discomfort of short-windness, Nancy spent the nights immediately preceding her surgery in a recliner ... thinking, planning and typing into her lap top computer. One of the things she wrote, thankfully discovered immediately after her death, was a complete outline of her funeral wishes ... the "who, what, when, where and why" down to the letter. A quote from her directive - "about the ... service, I'd really like to have it at Main Street (Methodist Church in Hattiesburg). A celebration service with a visitation before and a party afterwards would be the most fun... This is all crazy, but it's an idea! Important to me would be that so many of the people that I love and have blessed my life would get to meet each other..."

I never knew Nancy to be a party girl, but I hear they put on a fine one for her. The funeral itself that November 28 was a "Service of Praise and Thanksgiving and Celebration of the Life of Nancy O'Neal Tatum."

You have all read Nancy's obituaries and noted her many accomplishments. Nancy would no doubt have blushed to read them. Her many awards, her career in Medical Ethics, her teaching positions, offices held, and involvement

in church and community are all a matter of record.

Nancy, always seeking the “teachable moment” found one even in death. You see, Nancy, had this gift for bringing people together again. Those of us who could went to her funeral get-together that Thanksgiving weekend. I felt compelled during those days to simply try to contact some of our old school “running buddies” to let them know what happened. I found folks I hadn’t seen or spoken with in the 18 years since graduation. The calls seemed awkward at first, such bad news on the holiday. But, Nancy had taught me that there was never a wrong time to do the right thing. Each conversation with each old friend brought a litany of the blessings of shared memories to us both. Some of them are hazy ...

Dr. Cheryl Perkins recalled that “Nancy was always quietly better than most of us; she was always able to find a kinder, more compassionate resolution to difficult situations. She had a built-in empathy, a perspective we didn’t always see or even understand.”

We reminisced of a time when our entire class was in a stew over our rotating note-taking service which had become rather slip-shod.

Each day a different member of our class was responsible for recording lectures and distributing transcribed copies to the rest. Many students were turning in merely sloppy outlines, some did nothing. Most of the class was boiling mad over it, and constant bickering became the order of the day. But, one particular morning Nancy Tatum simply stood up and turned to all 150 of the class of 1980 and gave us an impromptu “Sermonette” that basically pointed out that the essence of our chosen profession was found in taking our responsibilities to others seriously. She did not come across as insulting or “holier-than-thou”. She did not dress us down. But everyone felt that conviction ... and she changed things for the better.

And she never stopped changing things.

\*\*\*

The core of Nancy’s calling was the restoration of nobility to the profession of medicine. She taught best by example.

She showed us that we should never let money be our god. Nancy lived a life of abiding preparedness for all circumstances, even for her own final “great adventure”. I have no doubt that she perceived those last few days in exactly that light.

And hers was a “life cut-off in the promise of such rich fruit.” Those of us who remain must shed our unspeakable sorrows and be filled with the joy of the gift of Nancy O’Neal Tatum. We must follow the map she left for us all.

—Dwalia S. South

*Member of the MSMA Board of Trustees*

## Important Date ■ Mark Your Calendar

**MSMA  
131st Annual Session  
May 14-16, 1999**

**Grand Casino Hotel  
Biloxi, Mississippi**



**Nancy O'Neal Tatum**  
**1950-1998**

## In Memorium

Dr. Nancy O'Neal Tatum, associate professor of family medicine at the University of Mississippi Medical Center, died of heart failure November 25, at Mississippi Baptist Medical Center. Services were held Saturday, November 28, at Main Street United Methodist Church in Hattiesburg. A memorial service was held Tuesday, December 8, at the University of Mississippi Medical Center (UMC).

She died following surgery to remove a tumor in her chest. At the time of her death she served on the Board of Trustees for the Mississippi State Medical Association. She served as co-chair of the Joint Practice Committee and was alternate delegate to the American Medical Association.

Tatum, 48, had been on the faculty at UMC since 1993. In addition to her teaching duties, she was chiefly responsible for establishing the Medical Center's formal ethics program which included continuing education on ethical issues and an ethics advisory committee whose members were available to both staff and patients.

"Dr. Tatum was a superb teacher and physician," said UMC vice chancellor Dr. Wallace Conerly. "Her thoughtful leadership in medical ethics made us all better care givers because she helped us look squarely at difficult problems that inevitably arise in the health professions. Her death leaves a great void in the lives of her colleagues."

Dr. Lessa Phillips, chair of the Department of Family Medicine at UMC said, "Dr. Tatum's love of family medicine and her love for teaching were exemplary. She was an extraordinary physician and teacher. No one could have cared for patients more or have been cared for more by her patients. She particularly loved those patients who were difficult, lonely and hopeless. Everyone who knew Dr. Tatum learned something from her by the way she handled her life and her career. She brought clinical ethics to the institution for the first time, and we are all better people for having known her. Her legacy requires that we always cherish our patients and recognize the divine privilege it is to care for them."

The Hattiesburg native was a 1968 graduate of Hattiesburg High School and a 1972 graduate of the University of Southern Mississippi (USM) where she was president of the Association of Women Students and of the Student Government Association. For three years following graduation, she taught choral music at Hattiesburg High School before returning to USM to complete prerequisite courses for medical school. She earned the MD and completed internship and residency training in family medicine at UMC. In 1996, she was a visiting scholar with the Harvard Macy Program for Physician Educators and in 1992 spent a year as visiting scholar at the Center for Clinical and Research Ethics at Vanderbilt University in Nashville, Tennessee.

As an undergraduate, she received the President's Citizenship Award at USM. In medical school, she received the CIBA award for outstanding community service. She was chief resident in family medicine and received the George Lally Bevill Award during her residency.

Dr. Tatum practiced family medicine in Petal with her father, the late Dr. A.T. Tatum, from 1983 until his death in 1992. At the time, they were the only father-daughter medical team practicing in the state. As a faculty member, Dr. Tatum also served the Medical Center on its Student Health Committee, the Patient Care committee, the Student Academic Awards Committee and the Institutional Effectiveness Committee. In 1994, she received the family medicine department's Golden Stethoscope Award as the students' choice of best teacher.

She was serving a term on the board of directors of the University of Southern Mississippi Foundation at the time of her death, and had recently completed a term on the board of directors of Whispering Pines Hospice and the Hattiesburg Civic Chorus and Concert Association. She was a member of Galloway United Methodist Church in Jackson.

She is survived by her mother, Martha R. Tatum of Hattiesburg; sister, Marty Lopez of Conroe, Texas; Anne McWilliams of Jackson; and brother, Toddy Tatum of Hattiesburg. Memorials may be made to the Nancy O. Tatum Scholarship at USM, the UMC Department of Family Medicine, the Whispering Pines Hospice or the USM Eagle Club.

## Women in Medicine Host Luncheon

A luncheon was recently held at the home of Shirley Schlessinger, M.D., Associate Professor, Department of Internal Medicine, Residency Program Director- Medicine, University of Mississippi School of Medicine (UMC), to bring MSMA Women in Medicine together with UMC women medical students, residents and faculty. It was the first time such an event has been held.

(left to right) Manisha Sethi, M.D., Medicine Resident; Valee Harisdangkul, M.D., Professor, Department of Medicine; Susan Jones, M.D., Medicine Resident; Lynn Diefenderfer, Medicine Resident; Sam Bush, M.D., Medicine Resident.



(left to right) Helen R. Turner, UMC Associate Dean, Academic Affairs and Mindy Mallory, M-3.





(left to right) Virginia Read, Ph.D., Chairman of Admissions, School of Medicine and Shirley Schlessinger, M.D., Associate Professor, Department of Internal Medicine, Residency Program Director-Medicine.



(left to right) Helen R. Turner, M.D., UMC Associate Dean, Academic Affairs; Suzanne T. Miller, M.D., Associate Professor, UMC Department of Pediatrics; Mary Gayle Armstrong, M.D., Family Practice-Public Health and June Powell, M.D., psychiatrist, converse with two UMC students.



(left to right) Bobbie West, M-4; Missy McMinn, M-4 and Melissa Duncan, M-4.



(left to right) Bethany Hairston, M-4; Kelly Clark, M-4; Shunte' Jones, M-3; and Tracy Townes-Bougard, M-4.



(left to right) Deborah Shure, M.D., UMC Professor of Medicine, Chief of Pulmonary Medicine and Emily R. Baillio, M.D., Internal Medicine.

## Community Acquired Pneumonia— A Success Story

Through the commitment of three Mississippi hospitals, the Community Acquired Pneumonia (CAP) project which began in October 1997 has already shown positive outcomes.

These hospitals participated in the *Pilot Community Acquired Pneumonia Project* utilizing a rapid improvement model. This model focuses on taking quick actions to improve a process, monitoring for results, then repeating these small cycles as necessary. This model, proven to be a useful tool for quality improvement, is now being shared with 40 collaborators statewide.

The project was initiated to identify opportunities for improvement in the inpatient treatment of Medicare patients 65 and over hospitalized with a diagnosis of pneumonia. The areas targeted by the three hospitals included:

- decrease of time between hospital arrival and initial antibiotic administration,
- decrease of time between hospital arrival and blood culture collection, and
- decrease of time to initial oxygenation assessment.

The chart adjacent shows aggregate baseline and follow-up data for April, May and June 1998 for the three participating hospitals.

### BACKGROUND

Data for the Medical Quality Indicator System (MQIS) pneumonia project demonstrated opportunities for improvement for the three indicators addressed in the CAP project. In MQIS, Mississippi ranked 28th in the nation for administration of antibiotics within four hours; 49th in the collection of blood cultures within 24 hours;

and 50th in the assessment of oxygenation within 24 hours.

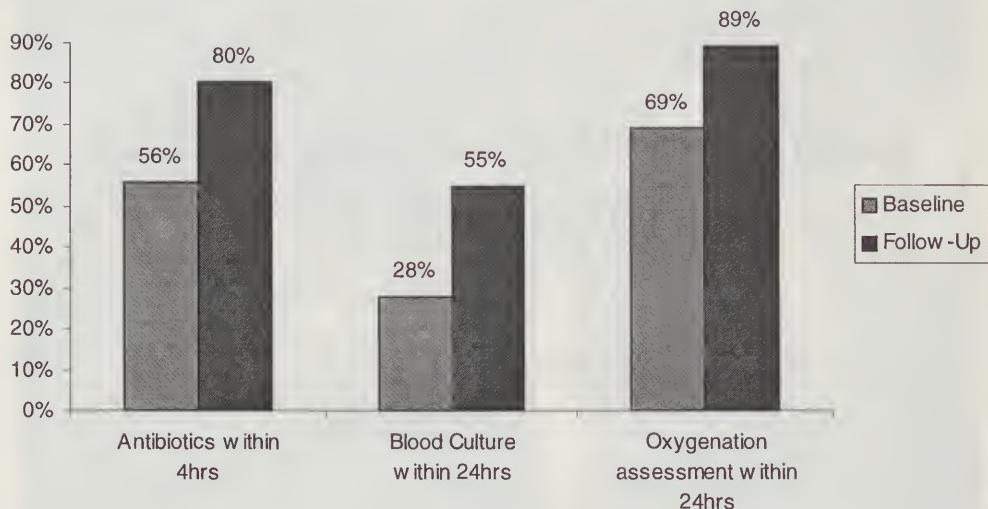
From the Medicare Part A claims data for January 1, 1996, through December 31, 1996, there were 6,003 DRG 089 (Simple Pneumonia and Pleurisy Age >17 with CC) cases representing 3.8 percent of the total Medicare discharges. Approximately five percent (5.05%) of all Medicare inpatient deaths and \$49,660,297 in Medicare expenditures are attributed to this DRG.

The chart adjacent shows the results of the aggregate baseline data collected by I.Q.H. from discharges from October 1, 1996, and September 30, 1997, from the collaborating 40 hospitals.

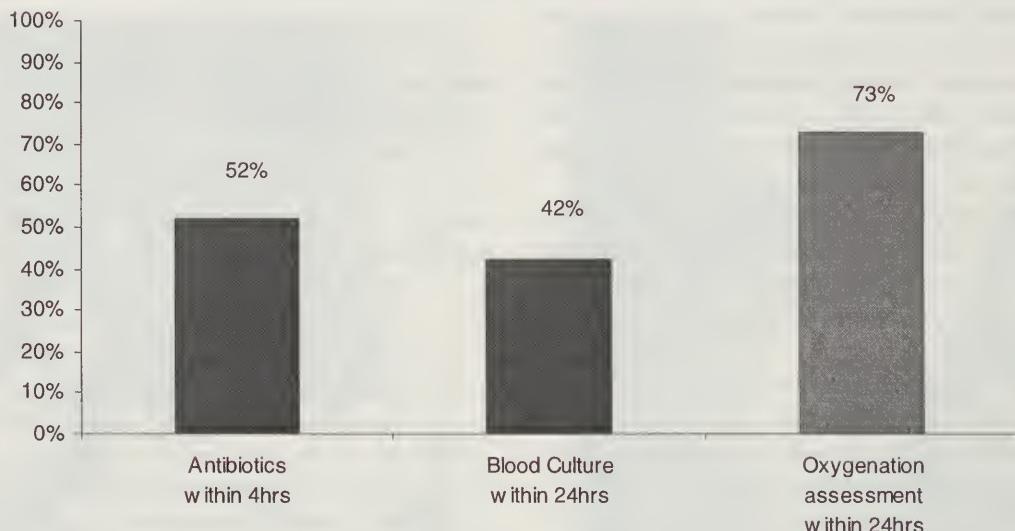
- The *antibiotic timing* indicator baseline analysis showed that 52 percent of the patients received an antibiotic in four hours or less. The location of the patient when the antibiotic was first administered can be useful in evaluating the processes involved in the timing of antibiotic administration with 80 percent of the patients receiving their first antibiotic on the floor.
- The *blood culture* timing indicator showed that out of all hospitals, 42 percent of the patients received a blood culture in 24 hours or less.
- A study for *oxygenation assessment* within 24 hours of arrival counted either pulse oximetry or arterial blood gas evaluation for this indicator. The percent of patients with oxygen assessed within 24 hours at all hospitals was 73.

For more information about this Health Care Quality Improvement project, contact project manager Kathie McAlexander, RN, or HCQIP manager Debbie Miller at 601-354-0304.

### Aggregate Baseline and Follow-Up Data for CAP Pilot Project



### Statewide Aggregate Baseline Data



The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcome.

## Personals

**David B Wheat, M.D.**, of Clinton, MS has received the degree of Fellow of the American Academy of Family Physicians (AAFP), the national medical association representing 85,000 family physicians, residents in family practice and medical students.

**John Madison Guice Sr., M.D.** has joined the Forrest General medical staff in the practice of urology. He will be affiliated with HubSouth Urology Clinic. A native of Laurel, Dr. Guice is a 1982 graduate of the University of Southern Mississippi. He received his medical degree from the University of Mississippi School of Medicine in 1986. He completed his internship in general surgery (1988) and a residency in urology (1989) at the Medical College of Virginia. He is board certified in urology.

**James Scott Manton, M.D.** has joined the Forrest General medical staff in the practice of internal medicine. He will be affiliated with Hattiesburg Clinic. A native of Columbia, Dr. Manton is a 1991 graduate of the University of Mississippi. He received his medical degree from the UM School of Medicine in 1995. He completed his internship and residency in internal medicine at the University of Tennessee at Chattanooga in 1996.

**Bernie J. McHugh, M.D.** has joined the Forrest General medi-

cal staff in the practice of neurosurgery. He will be affiliated with Hattiesburg Clinic. A native of Wilmington, Delaware, Dr. McHugh is a 1985 graduate of the University of Delaware. He received his medical degree from the Tulane University School of Medicine in 1992. He completed his internship in surgery at the University of Tennessee and a residency in neurosurgery in 1998.

**Stephen Eugene Massey, M.D.** has joined the Forest General medical staff in the practice of family medicine. He will be affiliated with the Urgent Care Center. A native of Kindersley, Canada, Dr. Massey is a 1981 graduate of the University of Alberta. He received his medical degree from the University of Alberta School of Medicine in 1983. He completed his residency in family medicine and psychiatry at the University of Alberta in 1985.

**Jack C. Evans, M.D.**, of Laurel, has been distinguished by his fellow physicians to appear in the *1998 Edition of the Best Doctors in America*. This is considered a singular honor and is awarded to physicians chosen in a detailed survey of peer review. Dr. Evans has practiced family medicine at Laurel Family Clinic in Laurel since 1983. He is board certified in family medicine.

**Francis Morrison, M.D.**, professor emeritus of medicine at the University of Mississippi Medical Center (UMC), was named president of the World Apheresis Association this year.

**Shelby K. Brantley, Jr., M.D.** was among 1,385 initiates who became Fellows of the American College of Surgeons during convocation ceremonies at the College's recent 84th annual Clinical Congress in Orlando, Florida. Dr. Brantley received a medical doctorate in 1987 from University of Mississippi and is currently practicing at Plastic Surgery Associates, P.A. located in the St. Dominic Medical Offices in Jackson. In 1996, Dr. Brantley received board certification from the American Board of Plastic Surgery. Dr. Brantley has a strong professional interest in cosmetic surgery, breast surgery and cosmetic lasers and holds membership in other professional societies, including the American Medical Association, Mississippi State Medical Association, American Society of Plastic and Reconstructive Surgeons, American Society for Aesthetic Plastic Surgery, American Society for Laser Medicine and Surgery, and the Lipoplasty Society.

**C. Ron Cannon, M.D.**, a Jackson-based otolaryngologist-head and neck surgeon has been elected president-elect of the Board of Governors of the American Academy of Otolaryngology-Head and Neck Surgery.

*The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.*

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## POSITION AVAILABLE:

Natchez Community Hospital in Natchez, MS has an immediate opening for a Medical Director for the Problem Wound and Hyperbaric Medicine program. The program has been established and in full operation for over two years. Office and staff are provided. This is an excellent opportunity for someone looking for their own practice in problem wound management and hyperbaric medicine. We are seeking someone that shares our interest in delivering quality medicine and following ethical business practice. **Please send CV to Marcus Healthcare Inc., 616 FM 1960 West, Suite 210, Houston, TX 77090. For more information contact Tom Holmes at (281) 893-8970 or (205) 647-0562.**

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## Meet the Staff

*Aside from interviews with members of the MSMA Executive Staff, in this issue of JOURNAL MSMA we thought you might like to know who answers the telephone when you call and is behind the front desk to greet you when you visit the Association.*

### Shirley R. Egger, Receptionist

**Years with Company:** New- Three Months.

**Previous Position:** Prior to accepting the position as Receptionist with MSMA I worked with Dr. J. Elmer Nix and Dr. Sidney R. Berry from 1977 to present.

**Business Philosophy:** Make sure you do any task given to you to the best of your ability.

**Favorite Thing About My Job:** Being associated with my fellow employees and seeing their attitude toward working together to make MSMA the company it is today.

**Hobbies:** Working in my vegetable garden and yard, sewing, cooking, collecting old chairs and refinishing furniture.

**Favorite Book:** *Left Behind* by Tim LeHay. I don't know if it is my favorite, but it certainly left a great impression on me.

**Favorite Movie:** *Roman Holiday* with Audrey Hepburn.

**Hometown:** I was born in Delta City, Mississippi in Sharkey county.

**Family:** I am one of ten children, six brothers and three sisters. Being third from the bottom, I could not wait to leave home and get out on my own. I moved to Jackson, Mississippi and went to work for the Mississippi State Rating Bureau. It was there I met and married my "White Knight in Shining Armor,"



..... Clifton Burnell Egger from Caledonia, Mississippi in Lowndes county. We have a daughter, Tracey E. Pettit and a son, Clifton B. Egger, Jr. I was a stay at home Mom for twenty years. We have five grandchildren. I lost my husband of thirty seven years in 1993 after a bout with cancer.

**Little Known Fact About Yourself:** What I have learned in the last five years, I am a survivor. Once I had to write a term paper on Abraham Lincoln and the one thing that has stayed with me was his Philosophy about life... "You are always as happy as you make yourself." How true! For me, in the last five years I've found one thing for sure... Life is a like a dance, you learn it one step at the time.

**Most Valued Virtue:** Honesty and Loyalty.

**Heroes:** My mother, for her sense of humor, after ten children and her graciousness. By far, my husband, for his demeanor, dignity and integrity.



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# JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MARCH

1999

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- Peritonsillar Abscess (PTA) in Children  
Ganglion Cysts at Field Memorial Hospital

## SPECIAL ARTICLES

- Status of Disease Management by Pharmacists  
A Challenge and an Opportunity for Organized Medicine

## PRESIDENT'S PAGE

- It's Up to Us

## EDITORIAL

- Unbearable Headaches





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**Cover photo:** D'Evereux: ca. 1840; Natchez, Mississippi, reflects pure Greek Revival architecture. Original furnishings of the builder include a rare set of china. On the National Register, D'Evereux is the home of Mrs. T. B. Buckles and Mr. and Mrs. Jack Benson. This spring photo was taken by Mickey P. Wallace, M.D., an otolaryngologist with the Ear, Nose & Throat Surgical Group, P.A. in Jackson.

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## Peritonsillar Abscess (PTA) in Children

C. Ron Cannon, M.D.  
Anthony Chambers, M.D.

**P**eritonsillar abscess is a consequence of acute tonsillitis, usually occurring in the young adult population. The occurrence in the pediatric population is not common, but may be increasing as tonsillectomy is not as commonly performed as in the past. The most appropriate management options include intravenous hydration, and antibiotics. Incision and drainage, with Quinsy tonsillectomy (acute removal of the inflamed tonsils) is recommended as the definitive treatment.

### INTRODUCTION

Peritonsillar abscess is a localized accumulation of pus within the peritonsillar tissues, usually resulting from suppurative infection of the tonsils. This process penetrates the tonsillar capsule (usually at a superior location) and extends into the connective tissue space between the capsule and the posterior wall of the tonsillar fossa. There, the infection may remain localized or can dissect through the constrictor muscle into the adjacent retropharyngeal space.<sup>1</sup>

As the most common deep space infection of the head and neck, peritonsillar abscess is increasing in prevalence probably because of deferring childhood tonsillectomy. Generally, however, young adults and older children are affected. The mean age stated by Beeden and Evans is between 20 and 30 years, affecting males and females equally.<sup>1</sup>

The purpose of this report is to demonstrate that younger children can develop peritonsillar abscess, report the microbiologic findings, review the pathophysiology

and discuss our current management protocol.

### MATERIALS AND METHODS

At the Head and Neck Surgical Group, ten children with peritonsillar abscess were treated over a ten year period. The patients ranged from ages 4 through 16, with 7 of the 10 patients being 10 years of age or younger. The racial distribution was 50% white and 50% black with the sex distribution also being evenly divided (Table I).

Microbiology results (Table II) revealed predominantly Streptococcus with Group A Streptococcus (2), Streptococcus viridans (4), and Streptococcus pyogenes (1). One patient with Streptococcus pyogenes also had a positive culture for *Bacteroides melanogenesis*. There were no other patients with anaerobic organisms. Mixed flora was grown from two other patients. One patient culture demonstrated no growth.

All patients were given antibiotics preoperatively and managed by incision and drainage of the abscess followed by Quinsy tonsillectomy. In our cases, the locations of the abscesses were evenly divided between right and left sides. No complications from the abscess itself or from the surgery were noted.

### COMMENT

The development of peritonsillar abscess (PTA) involves tissue necrosis and suppuration resulting in an abscess between the tonsillar capsule and the lateral pharyngeal wall, usually the supratonsillar space. As

**TABLE I**

Group demographics: Children with Peritonsillar abscess

n=10

Ages 4-16, Median 8

Male 5, Female 5

Black 5, White 5

Right sided abscess 5

Left sided abscess 5

**TABLE II**

Bacteriological Findings:

Group A Streptococcus 2

Streptococcus viridans 4

Streptococcus pyogenes\* 1

Mixed flora 2

No growth 1

\*This patient's culture also grew out Bacteroides melanogenesis

infection increases, the normal plane of cleavage between the tonsil and its underlying aponeurosis is obliterated.

Often associated with acute exudative follicular tonsillitis, the abscess primarily involves the supratonsillar space palate located immediately above the superior pole of the tonsil. As inflammation proceeds into the surrounding muscles, especially the pterygoids, spasm and trismus result. If untreated, it will rupture into the superior tonsillar crypt or may point and drain along the bulging of the soft palate, discharging its contents into the mouth.<sup>2</sup>

In the preantibiotic era, serious complications occurred when infectious spread occurred from a parapharyngeal infection, tracking along the carotid sheath. Fatal neurologic and hemorrhagic could result. Other complications from PTA include hemorrhage sequelae into the parapharyngeal space, endocarditis, sepsis, glomerulonephritis, polyarthritis, cervical abscess,

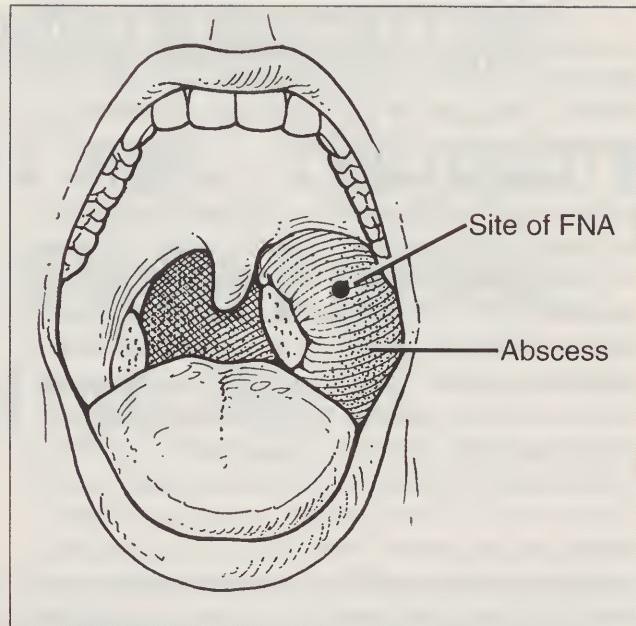


Fig. 1— Artist's depiction of Peritonsillar abscess. Peritonsillar abscess is characterized by edema, erythema and bulging of the affected tonsil. The optimal site for performing fine needle aspiration of a peritonsillar abscess is indicated. The uvula is often edematous and displaced past the midline to the opposite side.

airway obstruction, aspiration pneumonia, intracranial spread and death. Since the advent of antibiotics these are rare with few fatalities.<sup>2</sup>

Symptoms of PTA are sore throat, severe odynophagia, trismus, salivation with drooling, fever, headaches, tachycardia and malaise. Extreme distress and anxiety occur when the airway is compromised. Usually, the sore throat is of several days duration, but takes a turn for the worse despite antibiotics. Fever ranges from 102 to 105 degrees Fahrenheit. With dysphagia becoming prominent, the patient may not be able to eat or to swallow his or her secretions. Thus salivation with drooling occurs and the breath becomes rancid. Trismus results from inflammation of the pterygoid muscles. Speech becomes difficult and the voice assumes a characteristic nasal of thickened "hot potato" quality when the patient attempts to minimize pain on opening the mouth.

Examination of the throat in children can be difficult in the presence of trismus and may require judicious use of an oral topical anesthetic solution. When a true abscess is present, there is marked injection and edema of the involved peritonsillar tissues become markedly injected and edematous with bulging of the affected tonsillar pillar or soft palate. The uvula is often swollen and displaced past the midline toward the unaffected side. (Figure 1)

The differential diagnosis includes infectious mononucleosis, foreign bodies, tumors such as lymphomas, Hodgkin's disease, certain leukemias, extensive cervical adenitis, aneurysm of the internal carotid artery and dental infections.<sup>2</sup>

Appropriate management of PTA begins with a prompt diagnosis. Often patients will be treated for acute follicular tonsillitis only to be seen several days later with worsening throat symptoms. Although more commonly used in adults, fine needle aspiration through the affected tonsillar area may be helpful in selected children in making an accurate diagnosis of PTA.<sup>3</sup> A topical anesthetic sprayed into the oral cavity prior to needle aspiration is important. A 21 or 22 gauge needle is inserted 5 to 10 mm superior and lateral to the upper portion of the affected tonsil. This technique is extremely helpful in making the diagnosis of PTA. It is rarely successful in completely draining a PTA. If purulent material is obtained, it is sent immediately for culture and sensitivity before initiating antibiotic therapy.

Once the diagnosis of PTA is made, antibiotic therapy is instituted. Although penicillin will usually cover the organisms which cause PTA, treatment with a cephalosporin is preferred. Maisel, in a study of patients with PTA, compared serum and tissue levels of both penicillin and cephalosporins.<sup>4</sup> He found that the serum levels for both drugs were equivalent. In patients with PTA, however, tissue levels of cephalosporin were higher.

In children with PTA, incision and drainage (I & D) with Quinsy (immediate) tonsillectomy is recommended.<sup>5</sup> By proceeding directly with surgery, the patient's symptoms are relieved without the necessity for a prolonged hospitalization. The patients in this series were all treated as outpatients. It should be remembered that 10% of patients with PTA may have an inferior tonsillar abscess and another 10% will have a contralateral abscess. Either of which may be missed by a unilateral I & D procedure.<sup>6</sup> In years past, patients were treated by I & D and readmitted in 4-6 weeks for interval tonsillectomy. Immediate I & D with Quinsy tonsillectomy spares these patients an unnecessary repeat hospitalization and surgical procedure. Although recurrence of PTA after tonsillectomy has been reported, it was not seen in any patients in this series.<sup>7</sup>

## FUTURE IN DIAGNOSIS

Ultrasonography has recently been employed in verification of PTA. Using intraoral sonography, Haeggstrom, et. al, have demonstrated the possibility of accurately detecting the presence of an abscess, its volume, its location and its relation to the carotid artery.<sup>8</sup>

Although not widely performed, this procedure has the potential for non-invasive diagnosis of PTA.

## SUMMARY

1. PTA is more common in young adults, but does occur in young children. The average age in this present series was 8 years.
2. Children with progressive sore throat, sometimes despite antibiotics, should cause suspicion of a PTA. Edema and erythema of the affected tonsil with edema of the uvula and displacement toward the opposite side are classically seen.
3. In older or more cooperative children, fine needle aspiration of the affected tonsil allows prompt diagnosis of PTA.
4. Antibiotic therapy should consist of a cephalosporin owing to high tissue concentration within the inflamed peritonsillar tissue.
5. Definitive treatment is a Quinsy tonsillectomy. Immediate tonsillectomy not only drains the abscess, but also eliminates the potential for an occult inferior pole or contralateral abscess. It also spares the child a future hospitalization and surgical procedure.

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# Ganglion Cysts At Field Memorial Hospital

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## I ntroduction

Ganglions are cystic masses that are attached to an underlying joint capsule, tendon, or tendon sheath.<sup>7</sup> They are most commonly found in the hand or wrist, but may also occur at other various joints of the foot, shoulder, hip, and knee.<sup>6</sup> Grossly, the main cyst is white, smooth and translucent; the cyst's lumen is connected to the underlying joint or tendon sheath by a tortuous, continuous stalk.<sup>1,5,6,7</sup> Microscopically, ganglions are well-characterized<sup>1</sup>: the cyst wall is made up of compressed collagen fibers that lack epithelial or synovial cell lining. Within the cyst there is a clear, viscous and sticky mucin made up of glucosamine, albumin, globulin and hyaluronic acid.<sup>1,5,6,7</sup> Although their appearance macro- and microscopically is well described, the pathogenesis of ganglions remains poorly defined. A recent theory proposed by Angelides is that tissue trauma or irritation leads to the stretching of capsular and ligamentous supporting joint structures at the synovial-capsular interface. Modified synovial cells, mesenchymal cells or fibroblasts begin to secrete mucin; this mucin dissects through the joint capsule and ligament to form capsular ducts and lakes of mucin. The coalescence of these ducts and lakes leads to formation of a ganglion cyst.<sup>1,7</sup>

Whatever their origin, ganglion cysts have been described since Hippocrates' time.<sup>1,7</sup> They are benign tumors that typically cause complaints relating to cosmetic appearance (of a mass), pain or weakness.<sup>1,5,7</sup> Physical exam may be quite variable, depending on the location of the cyst.<sup>1,5,7</sup> Large ganglions are palpable cystic masses with various degrees of tenderness. Indications for treat-

ment of ganglions include pain, weakness and disfigurement.<sup>7</sup> Surgical excision is the most effective treatment for symptomatic patients.<sup>3</sup> The current study was undertaken to determine the recurrence rate of ganglions treated at Field Memorial Hospital in Centreville, Mississippi.

## MATERIALS AND METHODS

### Patient Population

A retrospective chart review was conducted for cases of ganglion cysts diagnosed and treated at Field Memorial Hospital, Centreville, Mississippi, between the years of 1993 and 1998. Charts were reviewed for patient characteristics, presenting symptoms, physical findings, cyst location, operative procedure and clinical course (i.e. incidence of recurrence). All surgically-treated patients had final diagnoses of ganglion cyst based on pathology reports. Long-term follow-up was determined, whenever possible, by telephone communication with patients. Cases that were diagnosed, but not treated, at Field Memorial Hospital, were excluded from the analysis.

### Treatments

Treatment of ganglion cyst cases involved either surgical excision or aspiration of the cyst followed by injection with triamcinolone. For surgical excisions, anesthesia was performed using a Bier 1 Block. Cysts were dissected away from surrounding structures and stalks were identified. Excisions were performed to include the entire stalk of the cyst down to the level of the

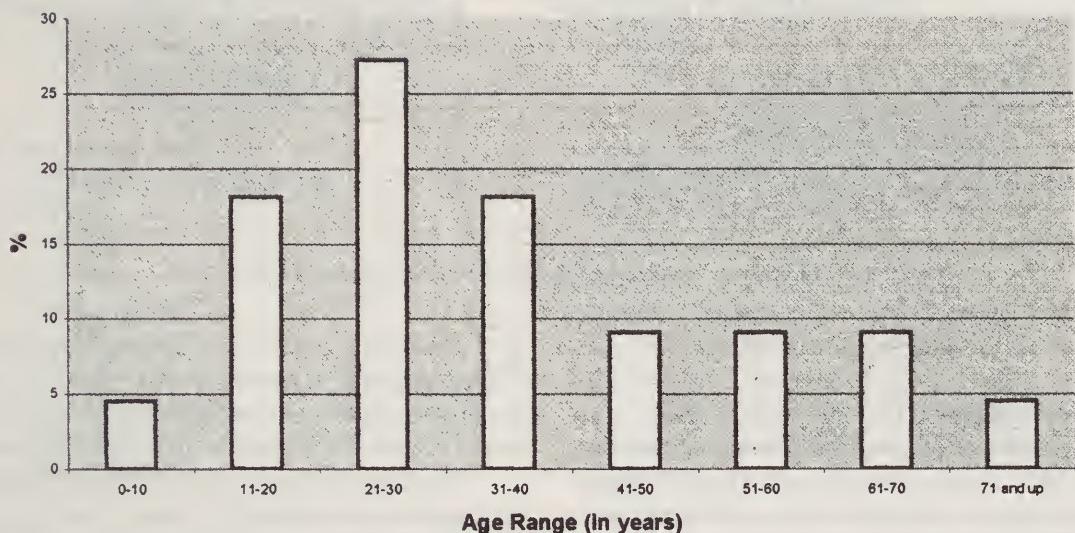


Fig 1.—Occurrence of ganglions by age, Field Memorial Hospital, 1993-1998.

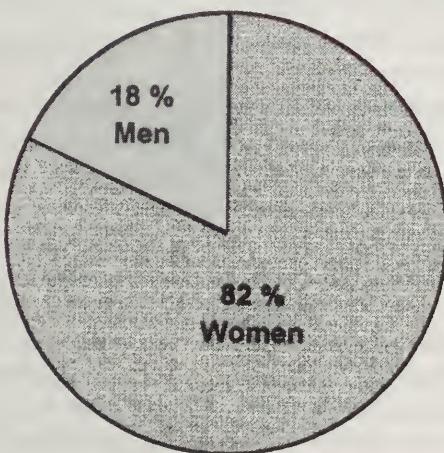


Fig 2.—Distribution of ganglions by gender at Field Memorial Hospital, 1993-1998.

joint. Whenever possible, cysts were excised intact, without puncture and pathologic diagnosis was confirmed after the operation.

## RESULTS

### Patient Characteristics

Between 1993 and 1998, a total of 23 charts with final diagnoses of ganglion cyst were reviewed. One case was excluded on the basis that the patient was diagnosed but not treated at Field Memorial Hospital.

Of the 22 remaining cases, 20 individual patients were identified. Patients ranged in age from 7 to 74 with a mean of 36.4 years (see Figure 1); male to female ratio was 18% men to 82% women (Figure 2). Occupations ranged in variety. Some patients were unemployed while others worked a great deal using their hands or were on their feet continuously during their work hours. None of our patients reported a previous history of trauma to the affected area.

Cysts were found in a variety of locations (Figure 3). The most common location (40% of all cases) was the dorsal wrist. The next most common location was the volar wrist, accounting for 15% of all cases. Other cyst locations on the hand (representing flexor tendon sheath accounted as a whole for 20% of ganglions treated. About 25% of ganglion cysts were located in the lower extremities, including posterior

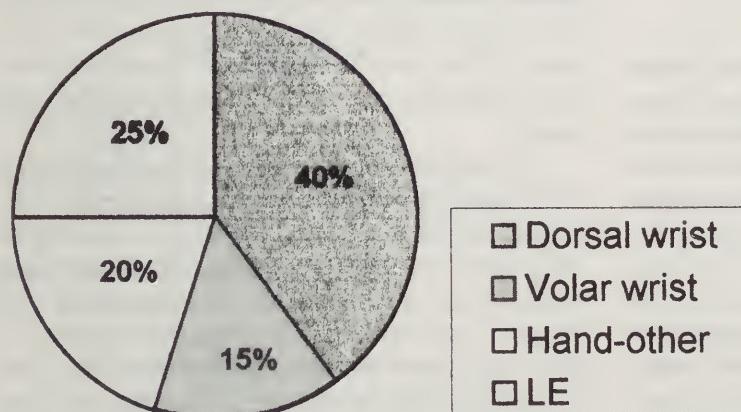


Fig 3.—Location of ganglions at Field Memorial Hospital, 1993-1998. LE refers to lower extremity.

Presenting Symptom	Number of Patients
Mass	15 (68%)
Pain at involved area	7 (32%)
Weakness involving affected joint	0 (0%)

Table 1.— Presenting symptoms of ganglions at Field Memorial Hospital, 1993-1998.

knee (1 case) and various locations in the feet.

### Patient Presentation

In this case study, the most common presenting symptom (68% of cases) was a mass (Table 1), which included descriptions of "lump, bump, swelling or cyst." The second presenting symptom was pain, noted by 32 % of patients. None of our patients presented with weakness as a presenting symptom.

### Operative Procedures

A total of 21 surgical excisions were performed on the 22 ganglion cyst cases at Field Memorial Hospital. Two of the 21 excisions were for recurrent ganglions. In cases involving upper extremity (hand or wrist) ganglions, a regional Bier block was used during surgery. In ganglions involving the lower extremity, local anesthesia with IV sedation was used. In all cases, patients tolerated the procedures well and recovered without further complications.

In one case, aspiration of a 4 cm<sup>2</sup> mass followed by injection with 1 cc of 40mg/cc triamcinolone was used to treat the ganglion cyst of the posterior knee. Prior to aspiration, lidocaine was injected subcutaneously for local anesthesia.

### Complications (Recurrences)

Nine percent of our patient population suffered a recurrence following treatment of their ganglions. These two patients had undergone surgical excision of volar wrist ganglions. Recurrences were treated with a second surgical excision. Following the second surgery, neither patient experienced a recurrence.

### Discussion

Ganglions are historically more common in women than in men (ratio of 3:1).<sup>1,2,7</sup> We observed a similar tendency in our case review, where 82% of patients were women. Ganglions tend to occur in persons between the second and up to the fourth decade. Again, our study

agreed with this prediction, with the highest percentage of cases occurring in this age group (Figure 1). Current literature recognizes no association of ganglions with type of occupation<sup>1,5,7</sup>; we found no correlation either.

Ganglions commonly produce a triad of presenting symptoms consisting of a mass, pain, or weakness.<sup>1,5,7</sup> Our patients experienced the first two symptoms; none presented with symptoms of weakness. In some cases, ganglions may cause symptoms associated with carpal tunnel syndrome, a snapping thumb or trigger finger. These symptoms occur when the ganglions impinge on nerves.<sup>7</sup>

Ganglions are clinically diagnosed based on history and physical exam.<sup>1,5,7</sup> A history of antecedent trauma is present in at least 10% of cases<sup>7</sup> but none of our patients described such an event. The physical findings in ganglion cases vary depending on size and location.<sup>5</sup> Occult ganglions may be difficult to diagnose<sup>5</sup>; often they are not physically apparent without extension of the underlying joint.<sup>1</sup> Sometimes they may not be physically identifiable at all; in these cases, diagnosis is based on history (usually of pain).<sup>5</sup> Transillumination of the cyst has been suggested although results are not always helpful.<sup>1</sup> During physical exam of volar wrist ganglions, the Alien's test must be performed and results documented prior to surgery in order to assess the adequacy of collateral blood flow to the hand.<sup>1,5,7</sup> This exam component is essential because volar cysts often sit in close proximity to the radial artery.

In our study, diagnosis of a ganglion was based on history and physical and, in all cases, surgical pathology. Several authors recommend radiologic evaluation using a wrist series in order to rule out bone or joint abnormalities (and to preclude an intraosseous cyst) that may be mimicking the patient's symptoms.<sup>1,5,7</sup> Newer diagnostic methods like MRI have also been used to visualize ganglions.<sup>1,7</sup> Ultrasound, however, seems to be proving a more useful tool, particularly in the case of occult ganglions.<sup>4</sup> Ultrasound images allow

## Differential Diagnosis of Ganglions

### Wrist Ganglions

#### Cysts and Neoplasms

- Epidermoid inclusion cyst
- Lipoma
- Xanthoma
- Fibroma
- Hemangioma
- Lymphangioma
- Osteochondroma
- Chondrosarcoma
- Synovial sarcoma
- Histiocytoma

#### Infections

- Mycobacterium
- Fungi
- Syphilis

#### Inflammation

- Gout
- Rheumatoid nodule
- Tenosynovitis
- Bursitis

#### Post-traumatic

- Scar
- Foreign body granuloma

#### Vascular

- Aneurysm
- Arteriovenous malformation

#### Muscular

- Anomalous muscle

### Hand Ganglions

#### Volar Retinacular

- Trigger Finger
- Giant Cell tumor
- Inclusion cyst

#### Distal Interphalyngeal Joint

- Giant cell tumor
- Inclusion cyst
- Heberden's node

characterization of the cyst and are helpful in differentiating cysts from conditions in the differential diagnosis (see Table 2).<sup>4,5</sup>

The most common soft tissue tumors of the hands and wrists are ganglions, accounting for 50-70% of such tumors.<sup>5,7</sup> In our study, 75% of ganglions were found in the hand or wrist whereas 25% were found in lower extremities- joints of the feet and in one case, the knee (Figure 3). Most ganglions (60-70%) occur in the dorsal hand or wrist where they typically arise from the scapholunate ligament<sup>1,2,5,7</sup>; most of our cases (40% of all cases; 53% of upper extremity ganglions) occurred at this location. The second most common region (18-20% of wrist ganglions) for ganglions is the volar wrist.<sup>1,5,7</sup> We had 15% of our cases (20% of upper extremity cases) occur in this location. The remaining upper extremity cases occurred in other locations on the hand. These locations represented flexor tendon sheath and volar retinacular sheath ganglions. Such cases represent significant but less common locations for ganglions in the hand.

Treatment for ganglion cysts includes non-operative and operative methods. For any treatment plan, it is important to stress to the patient that ganglions are non-malignant tumors. When patients are asymptomatic, conservative therapy consisting of reassurance may be all that is needed since spontaneous regression of ganglions has been observed to occur in 30-58% of patients.<sup>2,5,7</sup>

Other non-operative therapies include the traditional blow to the ganglion (using a Bible, dictionary or mallet).<sup>1,5,7</sup> Digital compression has also been used. Both methods work by bursting the cyst. Simple aspiration, heat, radiation, and sclerotherapy have all been used to treat ganglions. These methods are mentioned for historical interest and are now obsolete.<sup>1,5,7</sup>

Aspiration of cysts with subsequent injection of steroids is the current mainstay of nonoperative treatment. Ultrasound images can prove helpful in assisting aspiration.<sup>4</sup> Various steroid preparations have been used, including betamethasone, hydrocortisone and triamcinolone. A few years ago, triamcinolone was the recommended agent for injection.<sup>7</sup> However, reports of subcutaneous atrophy and skin depigmentation<sup>1,7</sup> have led to the more recent recommendation for using lidocaine and betamethasone.<sup>1,5,7</sup>

Surgical excision is the most effective means for treating ganglions.<sup>2,5</sup> All but one of our patients were treated with this method. Excisions should be performed in a fully equipped surgical suite.<sup>1,5,7</sup> For treatment to be effective, ganglion excision must extend the length of the

Table 2.— Differential diagnosis of ganglions, adapted from references 5 and 7.

stalk, down to the level of the joint capsule.<sup>1,5,7</sup> Failure to excise the entire ganglion and stalk predisposes patients to recurrence.<sup>1,5,7</sup> Keeping the ganglion intact during excision is helpful during excision because cyst rupture or decompression makes identification of its attachments difficult.<sup>7</sup>

In our surgical procedures, regional anesthesia using a Bier Block was performed. Some recent reports recommend using general or brachial block anesthesia instead of regional block because Bier blocks preclude tourniquet release.<sup>1,7</sup> We feel, however, that the Bier Block is a good method. By releasing the tourniquet and meticulously checking for hemostasis prior to closure<sup>5</sup> or by applying direct pressure for 5-10 minutes after closure, the risk of hematoma formation is minimal.

It is worth noting that historically, a number of other surgical procedures have been used to treat ganglions, including transfixion with a heavy suture to promote drainage) and subcutaneous tenotomy dissection.<sup>7</sup> These methods are disfavored now due to risk of infection.<sup>7</sup>

The reported cure rate for surgical excision of ganglions ranges between 85-95%.<sup>7</sup> In our study, the recurrence rate after surgical treatment was 9%. For this reason we feel that surgical excision is the best treatment for simple ganglions of the upper and lower extremity. Patients tolerate the procedure well and suffer very few complications, including recurrences, from such treatment.

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# Status of Disease Management by Pharmacists

Linda McMullen,  
MSMA General Counsel

**B**y now everyone has heard about Mississippi's Medicaid waiver authorizing pharmacists to be paid for disease management. The Health Care Financing Administration (HCFA) approved the waiver, which was the nation's first, in March of 1998. The amendment to the state's Medicaid plan became effective on April 1, 1998 and authorizes Medicaid reimbursement to pharmacists appropriately credentialed in four chronic disease states: diabetes, asthma, hyperlipidemia and coagulation disorders. Pharmacists are reimbursed up to \$20 for each encounter.

Already this pilot project is being used as the cornerstone of efforts in a dozen states to create similar programs and the success or failure of these efforts will be based largely on the Mississippi experience. **The Mississippi experience rests solely in the hands of physicians.** Physicians control the program because a pharmacist cannot qualify for reimbursement unless a Medicaid recipient has been referred to that pharmacist in writing. This article will address some of the questions and concerns that have arisen since the waiver took effect.

Approximately 70 Mississippi pharmacists have received the training necessary to apply for certification in disease management. Of those who passed the certifying examination in one or more of the four disease states, 27 have applied for eligibility in the Medicaid pilot program. As of February 5, 1999, only one patient-

specific written protocol had been filed with the State Board of Pharmacy.

The Division of Medicaid identifies the primary components of the program as the following: patient evaluation, compliance assessment, drug therapy review, disease state management according to clinical practice guidelines and patient education.

The theory of a coordinated approach to care involving a pharmacist is to effectively improve patient outcomes by providing an emphasis on educating and empowering patients to more successfully manage their own health care and reduce the possibility of improper medication use. The coordinated approach theory will not work without proper physician supervision and participation.

**The physician has the option of requesting disease management services from any credentialed pharmacist in Mississippi. A pharmacist cannot be reimbursed for any disease management services to any patient that has not been properly referred by a physician. Physicians must initiate the process. Further, the services provided by the pharmacist must be distinct from and cannot duplicate those provided by the physician.**

In order to provide the services, a pharmacist must be a registered pharmacist with a doctorate in pharmacy, or a registered pharmacist who has completed a disease-specific certification program approved by the Missis-

sippi State Board of Pharmacy. Such certification must be renewed every two years. In order to be eligible for the reimbursement of \$20 per visit, the pharmacist must sit down face-to-face with the recipient and dedicate 15-30 minutes to each consultation in a private area of the pharmacy. A Medicaid recipient is limited to 12 such consultations per year.

Before making such a referral a physician should know the pharmacist and be familiar with the pharmacist's qualifications. The physician should evaluate the patient in order to determine that the patient will benefit from disease management education or counseling. Finally, the physician must be prepared to participate and properly supervise the provision of the disease management services by the pharmacist.

The Mississippi pilot project is unique and prior to its inception there were no professional standards to give physicians guidance in collaborative practice areas. Because of this the Mississippi State Medical Association's (MSMA) Council on Medical Service toured the University of Mississippi Medical Center's School of Pharmacy at the Jackson Medical Mall. Council Chair Joe Ross of Vicksburg then led the panel's efforts to draft professional practice standards for physicians who are considering a collaborative practice. The Council's draft was reviewed by MSMA's Board of Trustees and will again be discussed at the Board's meeting this month. The Council and the Board of Trustees will recommend that the House of Delegates adopt the guidelines as the definitive standard of practice in Mississippi. Until the standards are finalized, a physician should approach a collaborative agreement with careful consideration.

The regulation promulgated by the Division of Medicaid requires all referrals to a pharmacist for disease management services to be in writing, and accompanied by an appropriate transfer of pharmacy care records and all laboratory test results. The referral must be dated and signed and must include an ICD-9-CM diagnosis code(s). Any referral is valid for only one year from the date executed. Although the Division of Medicaid regulation for disease management services by pharmacists does not expressly require a patient-specific written plan of care or protocol for education or counseling services, it is recommended that the physician prepare and enter into such an agreement with the pharmacist. Copies of the agreement should be in the physician's and the pharmacist's records and physicians and pharmacists are encouraged to file the protocols with the Board of Pharmacy and with the State Board of Medical Licensure.

If a physician is authorizing the pharmacist to

initiate or modify the prescribed drug therapy a more extensive patient specific protocol agreement is required.

Prior to the inception of the pilot project, Mississippi law allowed pharmacists to provide pharmaceutical health care by initiating and or modifying prescription drug therapies after a written protocol, indicating approval by a physician authorized to prescribe prescription drugs was approved by and filed with the State Board of Pharmacy. Physicians are encouraged to file this protocol with the State Board of Medical Licensure as well.

The protocol must define the agreement by which the physician delegates this authority and any such authority granted must be within the physician's prescribing authority and current practice. Protocol agreements must identify the physician who agrees to supervise the pharmacist and the scope of his or her medical practice and should describe the specific responsibilities authorized by the physician.

The protocol should describe the method the pharmacist will use to document decisions or recommendations the pharmacist makes to the physician and describe the patient activities the supervising physician requires the pharmacist to monitor. It should 1.) specifically state the types of reports the pharmacists will be required to provide to the physician and the schedule by which they will be provided, 2.) include a statement of the medication categories and the type of initiation and modification of drug therapy that the physician authorizes the pharmacist to perform, and 3.) describe the procedures or plan that the pharmacist should follow if the pharmacist exercises initiation and modification.

The protocol should also specifically state the termination date for the protocol, which can in no event be any later than one year from authorization. It must be dated and signed by the pharmacist and the physician and include a statement that stipulates that the patient has been notified by the pharmacist and the physician that the protocol agreement exists.

Finally, physicians should contact their liability carriers prior to referring a patient to a pharmacist for disease management services. Most policies provide that any liability a physician assumes under a written or oral contract or agreement that they would not otherwise have, or any liability arising from practicing medicine with someone who is not authorized to practice medicine, or any claim or lawsuit arising from postoperative treatment that has been relinquished by the physician and rendered by a non-physician will not be covered.

*If you have questions or need more information, please contact MSMA.*

# A Challenge and an Opportunity for Organized Medicine

Medicare prohibits the marking up of laboratory charges and requires the laboratory serving the patient to bill Medicare directly. Medicaid also prohibits these mark-ups and a number of states (California, New Jersey, New York, and others) also require "direct billing" by the laboratory. Direct billing for laboratory services is required in these states to prohibit improper billing of patients.

Our profession is bound by a defined standard of ethical conduct and a physician's behavior should be governed by adherence to the profession's ethical tenets. The AMA's Code of Medical Ethics provides that (Section 8.09):

*".....The physician's ethical responsibility is to provide patients with high-quality services... The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides low-cost laboratory services on which the patient is charged a profit is not acting in the best interests of the patient. However, if reliable, quality laboratory services are available at lower cost, the patient should have the benefit of the savings.... A physician should not charge a markup, commission, or profit on the services rendered by others. A markup is an excessive charge that exploits patients if it is nothing more than*

*a tacked-on amount for a service already provided and accounted for by the laboratory. A physician may make an acquisition charge or processing charge. The patient should be notified of any such charge in advance."*

Section 6.10 of the American Medical Association Code of Medical Ethics states that... "*..... No physician should bill or be paid for a service which is not performed; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically received. When services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately, if possible. A physician should not charge a markup, commission, or profit on the services rendered by others."*

In Mississippi, such mark-ups are unethical, but not illegal. Some physicians look at this loop-hole in the law as an opportunity to correct the historically low payment schedule for E&M services they provide. Some hospitals use this loop-hole as a means of correcting what has been a poor reimbursement from government sources. And, unfortunately, some physicians and hospitals egregiously mark up laboratory service charges and exploit patients. This system constitutes a challenge to organized medicine in our state and an opportunity to champion changes for the

sake of our patients.

In his book *Leading Change*, James O'Toole argues that values-based leadership brings change. Certainly the opportunity to prevent our patients from being exploited presents us with a values-based opportunity to change the current system.

How do we change the system? We can begin by persuading our colleagues not to continue these practices. We can circulate the pertinent sections of the Code of Ethics and we can argue that these practices, when given the light of day by media sources, will not be in our profession's best interests.

Should this persuasive effort fail, a legislative remedy would be prudent. The wisdom of the legislative remedy is that organized medicine would be the sponsoring party. It is our leadership, values-based, for the sake of our patients. It will easily carry the legislature (personal communication) and be enacted as it is revenue neutral (for the government) and pro-consumer in the eyes of politicians. The text of an example of appropriate legislation is as follows (adopted from California law):

*"It is unlawful for any person licensed in Mississippi or any clinical laboratory, or any health facility when billing for a clinical laboratory of the facility, to charge, bill, or otherwise solicit payment from any patient, client, or customer for any clinical laboratory service not actually rendered by the person or clinical laboratory or under his, her or its direct supervision unless the patient, client, or customer is apprised at the first time of the charge, billing, or solicitation of the name, address, and charges of the clinical laboratory performing the service. The first such written charge, bill, or other solicitation of payment shall separately set forth the name, address, and charges of the clinical laboratory concerned and shall clearly show whether or not the charge is included in the total of the account, bill, or charge. This subdivision shall be satisfied if the required disclosures are made to the third-party payer of the patient, client, or customer. If the patient is responsible for submitting the bill for the charges to the third-party payer, the bill provided to the patient for that purpose shall include the disclosures required by this section."*

*A clinical laboratory shall provide to each of its referring providers, upon request, a schedule of fees for services provided to patients of the referring provider. The schedule shall be provided within two working days after the clinical laboratory receives the request. For the purposes of this subdivision, a "referring provider" means any provider who has referred a patient to the*

*clinical laboratory in the preceding six-month period. A clinical laboratory that provides a list of laboratory services to a referring provider or to a potential referring provider shall include a schedule of fees for the laboratory services listed.*

*It is also unlawful for any person licensed in this state to charge additional charges for any clinical laboratory service that is not actually rendered by the licensee to the patient.*

*A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding ten thousand dollars (\$10,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison.*

*A violation of this section by a physician and surgeon for a first offense shall be subject to the exclusive remedy of reprimand by the Mississippi State Board of Medical Licensure if the transaction that is the subject of the violation involves a charge for a clinical laboratory service that is less than the charge would have been if the clinical laboratory providing the service billed a patient, client, or customer directly for the clinical laboratory service, and if that clinical laboratory charge is less than the charge listed in the clinical laboratory's schedule of fees pursuant to subdivision.*

*Nothing in this subdivision shall be construed to permit a physician and surgeon or a clinic to charge more than he or she was charged for the laboratory service by the clinical laboratory providing the service unless the additional charges for service."*

Other potential remedies, not driven by organized medicine, have onerous methods of achieving this same end. It would not be in the best interests of Mississippi physicians to have the regulators of our license be the enforcers of these reforms.

We urge the association to face up to this challenge. We urge the government to recognize that the incentive to mark-up lab charges stems from the inadequate reimbursement for E&M services. Let us agree that our profession chooses values-based vision for change. Let us agree that organized medicine supports direct billing by laboratories. Let us persuade our colleagues and hospitals to discontinue this onerous practice of mark-up. And if such persuasion fails, let us act together in the legislative arena.

— Mississippi Association of Pathologists



**Michael H. Carter, Jr., M.D.  
The President's Page**

## **It's Up to Us**

**T**he Mississippi Legislature has a profound effect on the practice of medicine in our state. The 174 members of the State House and Senate define through law exactly what constitutes the practice of medicine, as well as other health related professions including optometry, podiatry, chiropractic and nursing. They are asked annually to make revisions in the statutes to expand the scope of practice of non-physicians. That's why it is so important for organized medicine to take an active role in the legislative process.

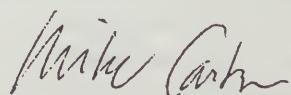
These are the same legislators who define minimum insurance coverage, fund the state public health programs, authorize Medicaid reimbursement and establish mental health, rehabilitation and other health care services.

As physicians, we have an obligation and responsibility to monitor bills pending before the State Legislature and advise our Senators and Representatives how these laws could impact health care delivery. Without our input, we are asking laymen to make health care decisions about which they have little or no training or knowledge.

With one month left in the 1999 legislative session, physicians still have time to make a difference. We can favorably impact state laws that regulate and affect the practice of medicine.

Watch for the weekly blue sheet and respond to the calls for action. Contact your State Representatives and Senators. Explain how pending legislation will affect the practice of medicine. Make it a priority to speak out for our profession and our patients. It's up to us to be part of the solution.

Increasing demands on practicing physicians make it easy to let someone else do the heavy lifting when it comes to calling, writing and meeting with lawmakers about pending legislation. But broad-based direct communication with our respective legislators enhances medicine's proper influence immensely and makes our association's lobbying efforts much more effective.

A handwritten signature in black ink that reads "Mike Carter".

# **Editorial**

JOURNAL OF THE  
MISSISSIPPI STATE MEDICAL ASSOCIATION  
VOLUME XXXX, NUMBER 3  
MARCH 1999

## **UNBEARABLE HEADACHES**

We all have 'em. Those pesky patients the appearance of whose names on our appointment schedules strike terror in our hearts, not to mention give new meaning to the term "irritable bowel syndrome." Like my elderly eccentric personal care home resident who recently dialed the police department to report the theft of her suppositories as rumors of an impending strip search spread like wildfire throughout the facility. But that's another story...

An even more notorious local commodity in the "Oh, no, not him again" patient category is Mr. Homer Simpson (whose name has been changed to protect the guilty). Homer's baggage includes severe chronic lumbosacral disc disease (status post several laminectomies), morbid obesity, chronic depression, long-suffering wife, and did I mention migraine headaches? Needless to say, it is this latter malady that seems to account for the majority of his frequent clinic and after hours/weekend emergency room visits.

Homer is well-versed in our regulatory-compliant ER policy requiring a designated driver for any patient receiving a mood-altering medication. So when he pulled into the hospital parking lot that Sunday morning, little note was taken by ER personnel of his passenger wearing a hat seated beside him.

Raising more than a few eyebrows, however, was what happened next. After receiving his usual injection and waiting the prescribed time on premises, Homer lumbered out to his vehicle and climbed into the passenger side as the other figure slid smoothly behind the wheel. Listing inexplicably toward the driver as the engine started, Homer maintained that awkward position as the automobile eased out of the parking space.

As Homer and his faithful friend slowly rounded the corner by an observation window, the mood in the ER switched from that of dutiful complacency to one of shocked amazement. For from this new vantage point it was clearly evident that Homer's escort was none other than a giant, stuffed panda bear sporting the latest in ursine haberdashery!

After the panda-monium (groan) had subsided, someone was heard to mutter, "Truth sure IS stranger than fiction!" The tale of Homer and his unlikely chauffeur has already passed into the annals of local medical folklore to be told and retold around the on-call campfire. After all, it's life's surprises which render our hectic existence "bearable."

**— D. Stanley Hartness, M.D.  
Associate Editor**

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

## Happy Doctors' Day

Listen, ye Doctors, and we shall make clear  
The projects we're doing in your honor this year!

We are an Alliance because we're with you  
So sit back and read all the things that we do.

Breast Cancer Awareness remains a top goal  
And Tar Wars shows kids not to smoke— young or old!

A Race for the Cure was Tupelo's way  
Of fighting breast cancer in a very big way!

We work in Teen Health Fairs and Sponsor-a-Spouse—  
Our River Run funds help support Haven House.

"Hands Aren't for Hitting" were given to schools—  
One thousand booklets with very good rules.

In 1999 the "BATTLE" is on—  
A Breast Cancer project that proves to be strong!

The Award of excellence from SMAA  
Went to Peggy and Emily for Breast Cancer  
"A"-wareness!).

Domestic Violence Shelters and Health Choice, too—  
Our way of helping as partners with you.

Five Health Awareness awards from AMA  
And Merrill as Prez-elect of SMAA!!

And now that you're "into" this outstanding list  
I'll tell you some more things you don't want to miss!

Salvation Army stockings were filled in December  
And a Welcome Coffee was held for new members.

At Christmas and Doctors Day, Sharing cards were sent  
For education and research, the funding was spent.

We also played "Santa" for kids not so blessed;  
And gave lots of Teddy Bears for little ER "guests."

Organ Donor awareness was brought to the light—  
And in health legislation we continued the fight!

Beauvoir Hospital Museum is exciting and new—  
We all need to work hard to make it come true.

The Mini-Internship program is simply one way  
To show Legislators a Doc's "typical" day!

For our Team Alliance, we all need to cheer—  
And the Legislative Phone Bank needs a strong ear!

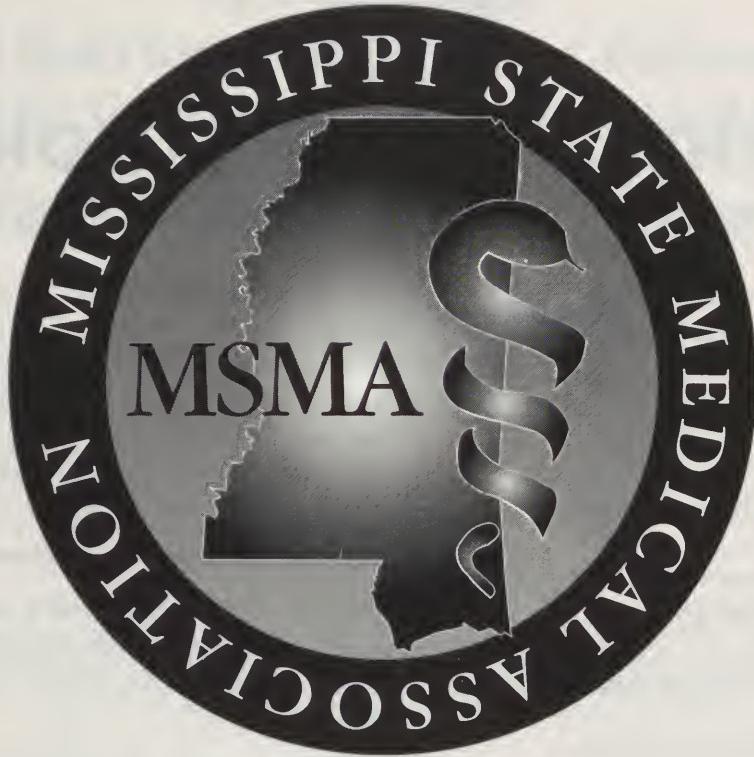
MMPAC and AMPAC are politically sound—  
We need to contribute so they'll stay around!

Medical Heritage shares interesting stories  
Of Mississippi physicians' heartbreaks and glories.

This is just a FEW of the projects we've done—  
Although we worked hard, we've had lots of fun!

As you read this list we hope this rings true:  
"Happy Doctors Day-- From our Alliance to YOU!"

—Ann Hopper  
*Pass Christian, Mississippi*  
*Gulfport / Coast Medical Alliance*



**131ST  
ANNUAL SESSION  
&  
SCIENTIFIC ASSEMBLY  
PRELIMINARY PROGRAM**

**May 14 - 16, 1999  
Grand Hotel & Resort, Biloxi, MS**

Supplement to The Journal of The Mississippi State Medical Association, March 1999



# GENERAL INFORMATION

## REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in all references committees as policies of the Association are established. All meetings will be held consecutively.

The schedule is as follows:

2:00 PM	Reference Committee on Constitution and Bylaws
2:30 PM	Reference Committee A
4:00 PM	Reference Committee B

## CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours for this session will be listed in the official program of the 131st Annual Session.

## MSMA ALLIANCE PROGRAM

The MSMA Alliance will hold its 76th Annual Session Meeting, May 14-16, at the Grand Hotel & Resort. A copy of the meeting agenda is enclosed with the Distaff.

Members and their spouses are invited to all social events which are all complimentary except the MSMA / MSMA Alliance reception and dinner featuring the Sotiles.

## THE PRESIDENT'S RECEPTION

The annual President's Reception will be held Friday evening, May 14, in the Ballroom of the Grand Bayview Hotel in Biloxi, from 6:30 PM to 8:00 PM. Tickets will be provided for a live performance in the Grand Theatre, which is adjacent to the hotel, following the reception. However, the name of the show has not been announced at this time.

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## MSMA/ MSMA ALLIANCE MEMBERSHIP PARTY TO FEATURE GUEST SPEAKERS WAYNE SOTILE, PH.D. AND MARY SOTILE, M.A.

The MSMA/MSMA Alliance Reception and Dinner will be held on Saturday evening, May 15, at 6:30 PM in the Grand Bayview Ballroom. An added attraction will be guest speakers Wayne Sotile, Ph.D. and his wife, Mary, co-authors of the groundbreaking book, *The Medical Marriage: A Couple's Survival Guide*, a fast-paced, humorous and compassionate look at the unique challenges that face today's physicians and their loved ones. The Sotiles will speak on "Managing the Stress of Medicine and Personal Relationships." Based on their experiences counseling over 600 physicians and their families, the Sotiles offer practical ways to maintain stress resilience as a medical family and enjoy each other in the process. Admission tickets will be available for \$25.00 per person to offset the costs for these nationally recognized speakers. The MSMA Alliance will once again hold a silent auction with proceeds benefiting the AMA Foundation. Association members and guests will have the opportunity to browse through the items for auction and make their silent bid before dinner. All items will be sold before the conclusion of the party.

# MSMA 131st Annual Session and Scientific Assembly

May 13-16, 1999

Grand Hotel Resort • Biloxi, MS • 1-800-354-2450

Deadline for Guaranteed Reservations: April 15, 1999

## PRELIMINARY SCHEDULE

### THURSDAY, MAY 13

1:00 p.m. Exhibitor set-up  
Registration  
1:00-4:30 p.m. Media/Speakers Training-Pat Clark  
4:30 p.m. Board of Trustees Meeting

### FRIDAY, MAY 14

7:30 a.m. Continental Breakfast with Exhibitors  
Specialty Society Breakfast:  
Mississippi Section of the  
American College of  
Obstetricians and Gynecologists  
8:00 a.m. Registration  
Reference Committee Members Breakfast  
9:00 a.m. House of Delegates  
11:00 a.m. Lunch with Exhibitors  
12 noon Board of Trustees Meeting  
Alliance Pre-Convention Meeting  
YPS Business Meeting  
MMPAC Board of Directors Meeting  
Cooperative Actions for Health Program  
(CAHP) / Medicine Public  
Health Initiative Program  
12:30 p.m. MPIC Stockholders Meeting  
Reference Committee on Constitution and  
Bylaws  
2:00 p.m. Reference Committee A  
4:00 p.m. Reference Committee B  
6:30 p.m. President's Reception  
8:00 p.m. Grand Theatre Live Performance  
(if available)  
9:30 p.m. Southern Medical Association Coffee and  
Dessert Party

### SATURDAY, MAY 15

7:00 a.m. Women in Medicine Breakfast  
7:30 a.m. Registration  
Continental Breakfast with Exhibitors  
Board of Trustees Meeting  
Specialty Society Breakfasts:  
MS Chapter of the American College  
of Surgeons  
Mississippi Society of Anesthesiologists  
Past President's Breakfast  
Fifty-Year Club Breakfast  
8:30 a.m. Plenary Session  
Alliance Welcome and Coffee  
MS State Dermatology Society Meeting  
9:00 a.m. Alliance House of Delegates Meeting  
11:30 a.m. Alliance Luncheon  
Specialty Luncheons:  
MS Academy of Family Physicians  
MS Chapter of the American College  
of Surgeons  
MS Society of Anesthesiologists  
MS Neurological Association  
12:00 p.m. Plenary Session  
1:00 p.m. Component Society Caucuses  
4:00 p.m. Alumni Receptions  
5:30 p.m. MSMA/MSMA Alliance Membership  
Cocktail Reception, Dinner and  
Silent Auction (Dinner speakers:  
Wayne Sotile, Ph.D. and Mary O.  
Sotile, M.A.-“Managing the Stress of  
Medical and Personal Relationships”)  
6:30 p.m.

### SUNDAY, MAY 16

7:00 a.m. Board of Trustees Meeting  
Continental Breakfast for Members  
7:30 a.m. Alliance Past-Presidents' Breakfast  
8:00 a.m. Worship Services  
9:00 a.m. House of Delegates  
12 noon Board of Trustees Meeting and Lunch  
Mississippi Association of Pathologists  
Meeting and Lunch (12-3:00 p.m.)

# **"MEDICAL PRACTICE IN A HIGH IMPACT SOCIETY" EDUCATIONAL PROGRAM**

(PRELIMINARY SCHEDULE)

## **PLENARY SESSION**

SATURDAY, MAY 15 • OASIS BALLROOM

8:30 A.M. **PANEL: "THE TREATMENT OF CHRONIC AND INTRACTABLE PAIN"**

•**CLINICAL PERSPECTIVE**

C. Anne Myers, M.D., Director

The Pain Clinic, Jackson, Mississippi

•**REGULATORY PERSPECTIVE**

W. Joseph Burnett, M.D., Executive Officer,

Mississippi State Board of Medical Licensure

9:45 A.M. **"SPORTS MEDICINE UPDATE"**

William B. Geissler, M.D., Associate Professor,

University of Mississippi School of Medicine

Department of Orthopedic Surgery

10:30 A.M. **"BUILDING A STATEWIDE TRAUMA SYSTEM IN MISSISSIPPI"**

•**PROGRESS REPORT**

Ed Thompson, M.D., State Public Health Officer

Mississippi State Department of Health

•**ESSENTIAL COMPONENTS FOR HOSPITALS AND MEDICAL STAFFS**

Frank Ehrlich, M.D., Chairman

Department of Surgery, St. Joseph's Hospital

Patterson, New Jersey

11:30 A.M. **LUNCH BREAK**

1:00 A.M. **"UPDATE ON ORGAN TRANSPLANTATION"**

- Sponsored by Mississippi Organ Recovery Agency (MORA)

•**A RECIPIENT'S PERSPECTIVE**

Phil Berry, Jr., M.D., Past-President,

Texas Medical Association

•**THE MISSISSIPPI ORGAN RECOVERY AGENCY (MORA)**

Shirley D. Schlessinger, M.D., Associate Professor

University of Mississippi School of Medicine

Department of Internal Medicine

2:30 P.M. **"MINIMIZING THE TRAUMA OF LITIGATION"** - Sponsored by MACM

(Speaker unconfirmed at press time, to be announced in next program)

3:15 P.M. **"HEALTH CARE LEGISLATION AND THE 106TH CONGRESS"**

Julius Hobson, Director of Congressional Affairs

American Medical Association

4:00 P.M. **ADJOURN**

**PLENARY PROGRAMS PLANNED BY MSMA's:  
COUNCIL ON SCIENTIFIC ASSEMBLY**



# Mississippi State Medical Association Alliance

76th Annual Session  
May 13-16, 1999  
Grand Hotel & Resort  
Biloxi, MS

## THURSDAY, MAY 13

1:00 AM - 4:00 PM Registration - 2nd Level

## FRIDAY, MAY 14

8:00 AM - Noon Registration - 2nd Level  
12:00 PM Pre-convention Board Meeting/Luncheon  
6:30 PM MSMA President's Reception

## SATURDAY, MAY 15

8:30 AM Alliance Welcome and Coffee  
9:00 AM House of Delegates  
11:30 AM Luncheon/ Installation of Officers  
1:00 PM - 5:00 PM View AMA-ERF Auction items  
2:00 PM Post-convention Board Meeting  
6:30 PM MSMA/ MSMAA Membership Cocktail Reception, Dinner  
& AMA Foundation Auction (Dinner speakers: Wayne Sotile,  
Ph.D. and Mary O. Sotile, M.A.- "Survival Guide for the  
Medical Marriage")

## SUNDAY, MAY 16

7:30 AM MSMAA Past Presidents' Breakfast

## Information and Quality Healthcare Update

This year is shaping up as another memorable one for I.Q.H., Information and Quality Healthcare. The imminent move from our present office to 385 Highland Colony Parkway in Ridgeland represents a significant change for the organization which has been located in the State Medical Building since 1987.

The new building offers I.Q.H. more than 13,000 square feet. Plans call for the Government Services Division, Operations Division, and Administration to be on the first floor. The Corporate Division staff will have offices on the second floor. A training room for a variety of classes and meetings will also be a part of the new location. Changes in the I.Q.H. telephone numbers may be necessary; we will update the physician community on any changes as soon as possible.

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This year also is highlighted with the beginning of the Sixth Scope of Work. A four-month extension of the Fifth Scope takes us to July 31, 1999, with the Sixth Scope of Work set to begin Aug. 1.

In this new contract with the Health Care Financing Administration, I.Q.H. will conduct both quality improvement and payment error prevention program work—or PEPP. The major emphasis will continue to be centered around health care quality improvement projects (HCQIP). PRO work under PEPP will involve projects directed both toward system improvement and individual case review.

I.Q.H. and other medical communities have consistently asserted that the PEPP portion of the Scope of Work should first be approached in a quality improvement project manner before proceeding to recoup individual payments. It is thought that HCFA will support this philosophy and allow the PRO discretion in determining when and how to pursue an individual case review approach.

Under the Fifth Scope of Work, I.Q.H. has successfully worked with several Mississippi hospitals in a special project to reduce avoidable readmissions. This project has been centered on a quality improvement approach rather than individual case review and payment denials.

This approach will be continued in the Sixth Scope of Work to the maximum degree allowed.

Regional meetings are planned to share information about the work required in our Sixth Scope of Work. The I.Q.H. Quality Forum scheduled for June 4-5 will also include a variety of informational sessions and the annual membership meeting.

Your questions and concerns are welcomed; please call me and share your thoughts. Understanding the work and supporting our efforts are essential to improving the quality of medical care to the Medicare population.

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The health care system is changing. (What an understatement!) We can all appreciate the fact that it is every physician's fundamental obligation to keep abreast of the changing scientific knowledge base of medicine.

I.Q.H. has a desire to assist with this need for updated knowledge by becoming an "information processor" on your behalf through our CQI projects and educational offerings. But physicians must also understand and respond appropriately to the changing nature of medical practice delivery to be truly effective and successful. We must be prepared to deliver high quality, cost-effective care in a new and continuously changing practice environment.

I.Q.H. is offering physician practice services education dealing with many of these issues. We are also dedicated to involving our Mississippi physicians in our utilization management processes and in our Medicare-required review so that we can maintain a leadership position in this arena. I.Q.H. cannot do this without your support. Now more than ever, we need your participation in our new 'Foundation,' our clinic education services, and our review activities, as well as your input on our future opportunities.

Let's continue to make 1999 the year for positive change leadership for Mississippi health care.

—*James S. McIlwain, M.D., I.Q.H.  
President, Principal Clinical Coordinator*

## Nurse Practitioners- Who Establishes the Standards of Care

The number of non-physician providers is growing. Some believe that the "long-standing concern about physician dominance of the health care system has led to measures that have facilitated the training and independence of these non-physician clinicians (NPC)".<sup>4</sup> Market forces view these NPCs as able to deliver more cost effective services. What has traditionally been within the purview of the physician is being questioned in a marketplace where many more traditional non-physician clinicians (optometrists, podiatrists, psychologists, CRNAs, and Certified Nurse Midwives) are being trained and where Advanced Practice Nurses (APNs) and Physician Assistants (PAs) are increasing in number and pressing for broadening of their scope of practice. These national trends beg the question, "who leads?". If physicians lead in establishing the standards of care, can they do so by trying to keep a status quo or must they help select and utilize the components of these groups that can maintain a high standard of medical care, provide cost effective care and satisfy the federal government that all of this is being done.<sup>4</sup> All of this is a tall order; the proposition of how to deal best with the relationship between physicians and nurse practitioners is a beginning.

Surely the constructive ideals of the medical profession and the nursing profession can come together to fuse a solution to the dilemma of the interdependence or the independence of these professions in the relationships of physicians and nursing practitioners and devise how best they can provide our society with appropriate, safe and effective medical care. The ball is in our court. The American Mississippi public at large cannot know best how to do this; the legislature cannot devise appropriate legislation to do so without the consideration of the issues

which can be most knowledgeably presented by nurses and doctors.

There is sufficient data to support the thesis that the best care will come from a team approach where nurse practitioners and physicians work as interdependent professionals. Done in this way with a team approach, cost effective use of skills and knowledge is obtained.<sup>1,2</sup> Despite different perceptions of studies favoring nurse practitioners or physicians in the delivery of care,<sup>1,2,3</sup> all agree that the team approach works better in terms of cost and quality of care. In an interdisciplinary program, the "enforced proximity of different disciplines" beget an atmosphere where boundaries and jurisdictions are defined and respect for the particular talents of each profession is gained. Such programs are being tried.<sup>4</sup>

Ideally, we need to move to the point where we can logically and civilly work in this cooperative way in order to best provide medical care for our society; however, there are differences that are heavy with us now making necessary direct discussion of these problems. The problems with which many states are dealing include the number of nurse practitioners, practice location, cost effectiveness, and the scope of practice. Consider what we know and we can predict with regard to these issues.

Nationally, there are an estimated 40,000 APNs in practice now (this exclusive of CRNAs and others grouped as traditional non-physician clinicians that altogether number 100,000). The APN number is expected to grow to more than 100,000 by year 2010. In Mississippi, a report compiled in 1997 indicated there were 882 Nurse Practitioners, which after exclusion of Nurse Midwives and CRNAs, reduced to 490 total APNs.<sup>1,5</sup> Expect a proportional growth in that number by 2010. How the APN and

physician generalist can pair up and work as teams could easily be determined.<sup>1,4</sup>

Evidence that the APNs are more likely to practice in the rural areas than general physicians is lacking and it is unreasonable to expect that these Nurse Practitioners would do so. Again, the team, rather than the individual clinician, may be the key which would allow for more free time and for more professional colleagues practicing in these areas.<sup>1</sup>

"The amount of actual cost saving to the health system that Nurse Practitioners can provide is not clear. According to Brown and Grimes, "recent meta analysis of care, outcomes, and cost effectiveness of nurses in primary care roles, NPs spend 25 minutes and physicians spend 17 minutes, on the average, with patients. Stated another way, NPs spend about 50 percent more time per patient. In addition, a physician's hourly work week is approximately 60 hours, compared with 40 hours worked

by NPs. However, a generalist earns about twice as much in salary as a NP. Roughly, this translates to equal cost per patient. Claims are made that cost savings occur because NPs order fewer tests and pay lower malpractice fees. No studies have yet been published that compare NPs with physicians using randomly assigned patients and controlling for differences in patient acuteness to determine need for diagnostic tests ordered and overall cost per visit."<sup>1</sup> In a collaborative team practice, the NP can spend more time with patients and manage their basic needs and the generalist physician is free to care for more complex problems.<sup>1</sup>

Defining the scope of practice is where "the devil may be in the details". The training of the NP is nursing, takes a nursing approach, and emphasizes the total needs of the patient and family, teaching, counseling and health maintenance. Physician orientation is primarily directed toward diagnosis and management of illness. A well-trained NP will have six years of training, including four years of

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college and two years in a Master's program (a portion of this in a preceptorship with the physician with whom the NP will be working). A generalist physician will have eleven years of training, including four years of college, four years of medical school and three years residency. Such a well-trained NP can provide health education, perform routine physical examinations, administer routine immunizations and diagnose and treat common illnesses, such as streptococcal pharyngitis. The physician is trained to care for a broader range of illnesses and to diagnose and manage complex medical problems. In a non-team setting, the NP is responsible for the patients not referred to the physician. In a team setting, however, the physician is accountable since it is assumed by the nature of the practice that physician input, if needed, is assured. So where the NP makes no referral, who is responsible if a serious illness is not recognized or a minor illness is improperly managed? The NP is responsible.<sup>1</sup> Dr. DeAngelis concludes in her article<sup>1</sup> that "we would not allow any scientific advance to involve patients without proper documentation of effectiveness and safety. We must use the same principle with independent practice of NPs. In the meantime, NPs should work with physicians as teams of interdependent professionals. Such practices allow for cost effective use of skills and knowledge of both professionals. Best of all, the patients benefit most."<sup>1</sup>

Turning our attention to the practice of Nurse Practitioners in Mississippi, several questions come to mind:

1. Is the NP who works in a free standing clinic the same as is described above as a team, independent or somewhere in between? There is, in reality, little reason to support the idea that this is a team arrangement. Although the nurse practitioner is not allowed by law to be an independent licensed practitioner in Mississippi, there is a sense that their practice in many cases may be carried on in an independent way in the clinics which are free standing. (Free standing as used here is in the sense that they are not in the same office with the responsible physician who signed off on their plan of practice.)

2. In such a setting, is physician input assured? While with some this may be so, who is to say? Consider that "as medical science becomes more complex, the task of the generalist becomes more difficult. Indeed, physicians' concern about dealing with the whole of medicine has been a stimulus for specialization."<sup>3</sup> We know that many times first primary care contact may be the place where the well-being of the patient depends on a correct diagnosis being made or the correct therapy given; how often needed physician input is obtained and assured when needed and in a timely manner in free standing clinics is not known.

3. Does 20 percent chart review and four hours per week with the nurse practitioner and the physician working together assure that a good standard of practice is being carried out? How could it be, considering the issues we have raised before? Even if such a review could assure such a standard, are these things done conscientiously and regularly?

4. What about legal liability? Although the NPs carry malpractice insurance, there is a liability on the part of the supervising/collaborating physicians. "Direction and supervision have traditionally not required the presence of the physician, but rather the overseeing and advising in performance of specific functions. Some, nonetheless, feel that 'over the shoulder' supervision is the surest way to avoid criminal or malpractice conviction and therefore the best policy. The further the deviation from this standard, the greater the risk of a criminal warrant being recommended."<sup>7</sup>

5. What are the views of the professional associations? Recommendations from the American College of Physicians<sup>9</sup> and the American Medical Association<sup>10</sup> are that nurse practitioners not be independent from physicians, but continue to work as a team until there is evidence based information documenting that the quality of the independent practice of nurse practitioners meets expected standards.

6. What are the C.M.E. requirements of the NPs and physicians in these settings? The ground work for change in medical education in the United States began in actions of the A.M.A. Council on Education, Henry P. Bowditch, Frederick C. Shattuck and others before 1910 when the Flexner Report, which catalyzed change in medical school education, was published.<sup>11,12</sup> Since that time progressive refinements have been made in requirements of medical education and in the postgraduate training of physicians. In addition, the Federation of State Medical Boards and their component state boards are pressing for means to assure a system of continuing education for doctors and for other measures to document continuing competency. There is no reasonable argument to oppose these efforts; however, it does seem altogether out of character that in light of this, we allow free standing Nurse Practitioner clinics where the educational requirements and demonstrated competency of the practitioners for complete patient care are much less.

The argument that there is an economic-competition issue here in opposing free standing Nurse Practitioner clinics may well be; however, the overriding issue is one of quality of care and the regulation of the scope of practice of these Nurse Practitioners, and who should ultimately be responsible for patients with complex problems and

serious illness.

We then conclude the future of the established standard of medical care may hang in the balance of our actions. Much needs to be done to assure that safe, appropriate, and effective care is obtained in the Nurse Practitioner clinics that are free standing. Solid support from the Mississippi State Board of Medical Licensure (MSBML) and the Mississippi State Medical Association (MSMA) is needed. Somehow, we need to seek out the ways to assure true collaboration with the Nurse Practitioners at these clinics, supervised by physicians licensed by the MSBML, and that these clinics are operating in such a manner that safe, appropriate and effective care is being delivered. To that end, the scope of practice of the Nurse Practitioners must have general guidelines set down by an official group (perhaps a committee established by legislation) composed of members of the MSBML and the Mississippi Board of Nursing (MBON) with a represen-

tative Nurse Practitioner and a physician who supervises NPs. In addition and within these general guidelines, we may need to consider a specific scope of practice that the supervising physician should, with the Nurse Practitioner, draw up that may further limit the specific NP to practice within his/her known skills and knowledge. The current function of protocols for that purpose is being diluted and rendered unwieldy by the submission of "national or standard protocols" that amount to copies of textbooks used in Nurse Practitioner programs, including everything they have ever been taught.

The interest of MSMA and MSBML in the defining of the role of the supervising physician in the physician NP relationship with regard to their practice in free standing clinics has been continual since the early 1980s. The need to define the scope of practice of the NP with regard to the Medical Practice Act has surfaced and resurfaced many times during the intervening years. It is clear that the



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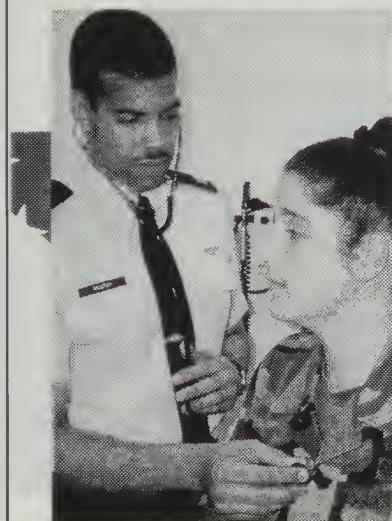
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legislative intent as interpreted by the Attorney General's office is that any changes in the scope of practice and other rules and regulations governing the Nurse Practitioner's practice be agreed upon jointly by the MSBML and MBON. With the guidance of the law, and the cooperative efforts of the MSMA, MSBML and MBON, we can establish medical practices that are most beneficial to the citizens of Mississippi.

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# Personals

**Sheila G. Lindley, M.D.** was among 1,385 initiates from around the world who became Fellows of the American College of Surgeons during convocation ceremonies at the College's recent 84th annual Clinical Congress in Orlando, Florida. Dr. Lindley received her medical doctorate in 1984 at the University of Arkansas, completed her general surgery residency at Creighton University and completed a plastic surgery fellowship at the University of Utah. She was senior registrar in Pediatric Plastic Surgery at the Hospital for Sick Children in London, completed an AO fellowship in Bern, Switzerland, and was a Hand and Microsurgery Fellow at the Kleinert Institute in Louisville, Kentucky. Dr. Lindley has been in private practice since 1994 and has practiced with Plastic Surgery Associates since 1996. Dr. Lindley is board certified by the American Board of Surgery. She received the Certificate of Added Qualification in Hand Surgery, and is certified by the American Board of Plastic Surgery. Her professional society memberships include American Medical Association, American Association for Hand Surgery, Southern Medical Association and Central Medical Society of Mississippi. Her professional interests include upper extremity reconstructive surgery and microsurgery and congenital hand surgery.

**David Richardson, M.D.**, has joined the staff of Franklin County Memorial Hospital Senior Care as medical director. Dr. Richardson, from Jackson, holds a B.S. degree from Mississippi College, attended graduate school at the University of Mississippi and received his medical degree from the University of Mississippi Medical Center. He completed his residency in psychiatry at Baylor College of Medicine. While at Baylor, he was chief resident for the department of psychiatry. He is also a clinical professor for the University Medical Center and has a private practice in Jackson. He is a member of several medical organizations including the American Medical Association, American Psychiatric Association, Mississippi Psychiatric Association, Southern Psychiatric Society and Central Medical Society.

**John P. Arena, M.D.**, a pulmonary medicine physician at Hattiesburg Clinic, recently coauthored an article entitled "Persistent Pleural Effusions following Coronary Bypass Surgery." The article was published in the Pulmonary and Critical Care Pearls section of *Chest*, a medical journal. A native of Sulphur, Louisiana, Arena received his medical and specialty training at Louisiana State University Medical Center. He joined Hattiesburg Clinic in July 1997.

**Guy Farmer, M.D.** and his Calhoun City Medical Clinic Laboratory have been recognized for Quality Laboratory Services. Dr. Farmer has met all criteria for Laboratory Accreditation by COLA, a national healthcare accreditation organization. Accreditation is given only to laboratories that apply rigid standards of quality in day-to-day operations, testing, and

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pass a rigorous on-site laboratory survey. Dr. Farmer has earned COLA accreditation as a result of long-term commitment to provide quality service to his patients.

**Charles A. Hollingshead, M.D.** has recently joined River Oaks Health System's East River Clinic as a family medicine practitioner. The East River Clinic is part of The Preferred Medical Network. Dr. Hollingshead has acquired 32 years of experience as a family practitioner and served as a senior partner of a four-physician family practice clinic in Laurel, Mississippi for 20 years as well as a partner and staff physician with MEA Medical Clinic for several years. Most recently, he served as an assistant professor in the Department of Family Medicine at the University of Mississippi Medical Center in Jackson, Mississippi, and as the medical director for the West Jackson Family Medical Center of the University of Mississippi Medical Center. In 1956, Dr.

Hollingshead received a bachelor of science degree from the University of Southern Mississippi in Hattiesburg, Mississippi. He received his medical degree from the University of Mississippi School of Medicine in Jackson, Mississippi in 1964. In 1965, he completed a rotating internship at Mobile General Hospital in Mobile, Alabama.

**C. Ron Cannon, M.D.,** a Jackson-based otolaryngologist-head and neck surgeon, has been chosen by his colleagues as president-elect of the Board of Governors of the American Academy of Otolaryngology-Head and Neck Surgery. Dr. Cannon was elected during the Academy Foundation's annual meeting in San Antonio, Texas. He became the first Mississippian elected to this position.

**Ed Thompson, M.D., MPH,** will lead the national Association of State and Territorial Health Officials for the next year as its president. Dr. Thompson is Mississippi's State Health Officer and chief executive officer of the Mississippi State Department of Health. Since his appointment in 1993, he has led the 3,000-employee agency to "deal with change by design" through central office reorganization, decentralization, and training. Dr. Thompson has been an active member of ASTHO, chairing its Government Relations Committee and serving as a member of the Infectious Disease Committee. Most recently, he served as ASTHO's Secretary-Treasurer.

**Jimmy Meeks, M.D.,** family physician, has joined North Mississippi Health Services Corinth Family Medical Clinic. He completed his undergraduate studies at Mississippi State University, his medical studies at the University of Mississippi School of Medicine and his family practice internship and residency at Spartanburg General Hospital in Spartanburg, S.C.

**Jeremiah Henry Holleman, M.D.,** of Columbus has written a book entitled "*An Unbroken Chain.*" The book is the surgeon's memoirs of his rural southern childhood during the Great Depression and the subsequent struggles and events that led to his completing medical school and service as a military surgeon in World War II and Korea. The Forest County native spent his youth and childhood in Madison County. He received his M.D. degree from the University of Tennessee Medical School in 1943.

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## Meet the Staff

*This feature continues with MSMA's executive staff profiles.*

### Deborah Batzing, CPA Director of Finance and Administration

**Years with company:** One year on March 9, 1999.

**Previous positions:** Worked in the Controller Department at Deposit Guaranty National Bank, as Director of Accounting at Rankin Medical Center, as the Controller at Madison County Medical Center and as a Medicare Auditor at Blue Cross Blue Shield of Mississippi.

**Favorite thing about profession:** It's always a challenge.

**Favorite books:** I don't have an all time favorite book. My favorites always change. Recently, I enjoyed *The Gold Coast*. I like books with well defined characters that have a sense of humor.

**Recently read:** *The Winner, Deception on His Mind, One True Thing.*

**Hobbies:** Gardening, reading, floating in my pool with a good book and a cold drink.

**Hometown:** Honeoye Fall, New York. Actually it was too small to be a town. It was a village.



**Family:** My husband Tom of 15 years. Our "Boys" Gunther (our Boxer) and Bruno (our Chocolate Lab). My cats Emmett & Chloe. My sister's cats, Misty & Kelsey, which we adopted when my sister recently passed away. Also my parents in Georgia and my niece in Texas.

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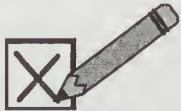
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## Long-Term Outcome of Infants at the Margin of Viability

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**A**bstract: The outcome of babies at extremely short gestational age (22 to 26 weeks) effects our clinical decisions regarding their care. We looked at survival and presence of disability at  $25 \pm 11$  months of age in 246 of these infants born at our hospital between 1992 and 1996 who were average weight for gestational age. Babies were evaluated in our follow up clinic by a pediatrician, and a physical therapist for cerebral palsy, blindness and deafness, and by a psychologist with the Bayley II. Chances for survival without disability exceeded 50% of live born infants at 25 weeks gestation or a birth weight of 700 to 800 grams. Chances for survival exceeded 50 % of live born infants at 24 weeks gestation or a birth weight of 600 to 700 grams. Chances for intact survival reached 50% of survivors at 23 weeks gestation or a birth weight of 400 to 500 grams.

### Key words:

Second trimester pregnancy outcome,  
premature labor,  
long term outcome,  
cerebral palsy,  
retinopathy of prematurity,  
mental retardation,  
extreme preterm birth,  
extreme low birth weight.

Neonatologists and obstetricians are frequently confronted with critical decisions concerning babies at the threshold of viability (22 to 26 weeks). If at this gestation

the fetus is not growing should delivery be induced? If during labor the fetus has an abnormal heart rate tracing, at what gestation is the risk of cesarean section to the mother outweighed by the potential benefit to the infant? If the infant is born limp and cyanotic, at what birth weight and gestation is resuscitation appropriate? A physician called to the delivery of a 600 gram, 24 week infant is faced with medical decision making in an area of uncertainty. The ethical principle of beneficence (preserve life) and maleficence (do no harm) may conflict. These decisions should be based on up to date data on the outcome in this 22 to 26 week group. We have been prospectively collecting clinical data both on immediate neonatal outcome and on long term outcome for these infants in our follow-up program. We reviewed our experience to see how well or how poorly these infants were doing.

### Methods

As the statewide referral center for perinatal care, University Medical Center receives large numbers of maternal transports where extremely premature delivery is expected. Newborn intensive care unit (NICU) clinical data has been entered into a database since 1985. NICU survivors are enrolled in the Neonatal Follow up Program to provide care and determine long term outcome. This data was obtained from the clinic database or by reviewing the charts.

Data on infants born at University of Mississippi Medical Center between August 1992 and August 1996

were analyzed. Our plan was to obtain data on a four-year period, but to require that all infants be at least 2 years old at the time of data analysis so follow up data would be available. Throughout this period, the general policy of the Newborn Division, in consultation with the parents, has been to initiate resuscitation on all newborns of greater than 400 grams birth weight who show signs of life in the delivery room. Surfactant was given in the delivery room to extremely immature infants needing intubation.

Decisions regarding cesarean delivery for fetal indications for infants in this gestational age group were made in consultation with the parents. The general obstetrical policy was to dissuade parents from pursuing cesarean delivery in pregnancies of less than 26 weeks gestation with a less than 600 gram estimated fetal weight. Obstetrically, efforts to stop labor were aggressively pursued, and Betamethasone was given to promote fetal lung maturation. We attempted to see all surviving infants at follow-up clinic two weeks after their discharge and again at 9 months, 18 months, and yearly thereafter. A careful physical exam was done by both a pediatrician and a physical therapist looking for signs of cerebral palsy at all exams after two weeks. The Bayley Scale of Infant Development 2<sup>nd</sup> ed. (Psychological Corp., New York) was performed by a developmental psychologist (T. R.) at the 18, and 30 month exams using corrected age to calculate the developmental quotient. After 30 months a Stanford Binet IQ test was performed. The latest available test results were used. The average age at testing was  $25 \pm 11$  months (standard deviation). These children were seen by an ophthalmologist in the nursery to screen for retinopathy of prematurity and then followed as needed on an out patient basis. All infants were screened for hearing loss in the nursery and followed up on an out patient basis.

Survival data is complete until discharge from the nursery. If we became aware of an infant dying after discharge we coded accordingly. Ultrasound examinations for intraventricular hemorrhage were routinely done between 10 and 14 days of life with follow-ups thereafter as needed. Only one of five physicians in the newborn group was using prophylactic indomethacin to prevent intraventricular hemorrhage during this period.<sup>1</sup>

Infants were classified as **intact** if they were neither blind nor deaf, had no cerebral palsy, and had a Bayley score within 2 standard deviations from the mean at a postnatal age of greater than one year. Children without formal psychological testing performed at a postnatal age of at least one year were considered lost to follow up, unless it was apparent that they would be severely dis-

abled at the time of the last visit (ex. spastic quadriplegia, blindness or deafness). A child was classified as having **mild to moderate** disability if: 1) He was blind in one eye or deaf in one ear, or 2) He had cerebral palsy, either hemiplegia or diplegia but could walk, or 3) He had a developmental quotient of more than 2 standard deviations below the mean, but less than 3 standard deviations below the mean. Myopia alone was not considered a disability. A child was considered to have **severe** disability if: 1) He was blind in both eyes or deaf in both ears, or 2) He had spastic quadriplegia or hemiplegia or diplegia so severe that he could not walk, or 3) He had a developmental quotient of more than 3 standard deviations below the mean, or 4) He had multiple moderate disabilities.

Gestational age was determined by obstetrical dates if this was within two weeks of the pediatric physical exam dates, or by pediatric physical exam dates if this was not the case. To avoid grossly erroneous gestational age estimates, only average for gestational age infants were included, those between the 10<sup>th</sup> and 90<sup>th</sup> percentile of weight for gestational age.<sup>2</sup> All live born infants were included in the analysis, whether or not they were admitted to the Newborn Intensive Care Unit.

## Results

Figure 1 shows by gestational age the percent of live born infants who survived, those who survived and were normal on follow-up, and those who survived with either mild to moderate or severe disability. Similar data by birth weight is shown in Figure 2. The number of live born infants by gestation and by birth weight during this period and the number who survived and for which follow up data was available is shown in Table 1.

An important question to answer is whether the patients who returned for follow up were systematically different from those for whom follow-up was not available. Thus we chose a group of infants who were at high risk for long-term disability at the time they left the nursery. The group with the greatest risk of disability, based on data available at hospital discharge, was the babies with Grade III or IV intraventricular hemorrhage or Grade IV retinopathy. Adding data on chronic lung disease or milder retinopathy, as has been done in some of the Neonatal Network studies<sup>3,4</sup>, reduced the specificity for detecting disability in our data. The percent of infants at high risk for disability who were lost to follow up was 29%, which is almost identical to the percent of infants who were not at high risk for disability who were lost to follow up of 26% ( $p=ns$ ). Thus the assumption implicit in the analysis, that the babies for which follow

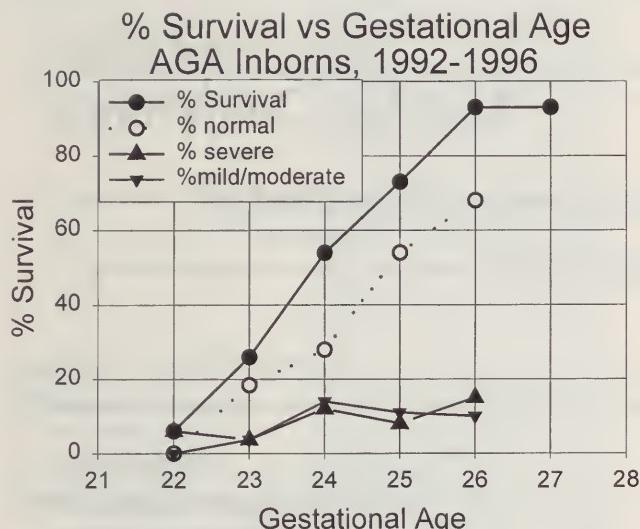


Fig 1.—This figure shows the percent of the live born, average for gestational age infants, born at University Medical Center by gestation: 1) Who survived (solid circle), 2) Who were normal at follow up (open circle), 3) Who had mild or moderate disability at follow up (triangle pointing down), or 4) Who had severe disability at follow up (triangle pointing up). For example at 24 weeks 46% of the infants died and 54% lived. We can further subdivide the 54% who lived into 28% who were normal at follow up, 14% with mild to moderate disability and 12% with severe disability (54% = 28% + 14% + 12%). At 26 weeks gestation there were 71 infants of which 66 survived and 37 returned for follow up evaluation. At 25 weeks there were 74 infants of which 54 survived and 39 were followed. At 24 weeks there were 54 infants of which 29 survived and 23 were followed. At 23 weeks there were 31 infants of which 8 survived and 7 were followed. At 22 weeks there were 16 infants of which 1 survived and 1 was followed.

up data was available were representative of the entire population, appears to be sound.

## Discussion

Outcome for very immature and very small babies has improved rapidly over the years.<sup>5</sup> At the University of Mississippi Medical Center, over one-half of the babies who are born alive at 25 weeks gestation or at a birth weight of 700 to 800 grams were discharged alive and had no disabilities at follow up. Even at 24 weeks gestation or a birth weight of 600 to 700 grams, over one-half of the infants survived. Even at 23 weeks gestation or a birth weight of 400 to 500 grams, 50% or more of the surviving infants were intact at follow up. However the number of surviving infants below 24 weeks gestation or 600 grams birth weight is small and the statistical uncertainty on the outcome for this group is large.

Lastly, because a child is declared intact at one and

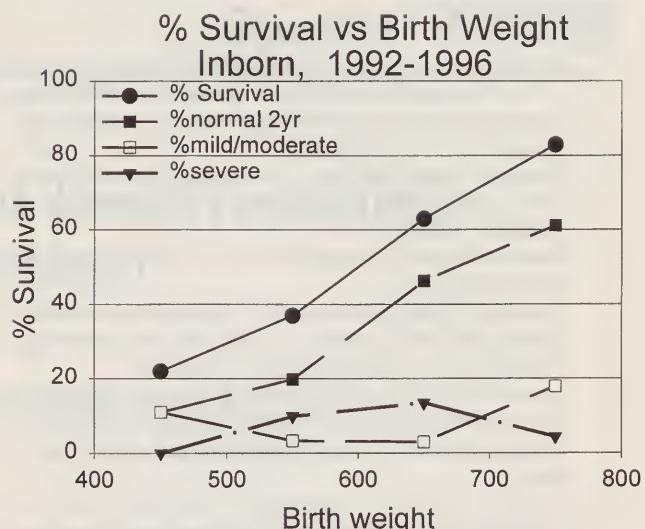


Fig 2.—This figure shows the percent of the live born, average for gestational age infants, born at University Medical Center by birth weight: 1) Who survived (solid circle), 2) Who were normal at follow up (solid square), 3) Who had mild or moderate disability at follow up (open square), or 4) Who had severe disability at follow up (solid triangle). At a birth weight of 701 to 800 grams birth there were 88 infants of which 73 survived and 39 returned for follow up evaluation. At 601 to 700 grams there were 86 infants of which 54 survived and 42 were followed. At 501 to 600 grams there were 40 infants of which 13 survived and 10 were followed. At 400 to 500 grams there were 23 infants of which 5 survived and 4 were followed.

one-half years does not mean that he has escaped unscathed. Numerous investigators<sup>6,7</sup> have described a higher incidence of school problems and learning disabilities when these children reach school age. Learning disabilities and school problems are common even after full term birth. Although early remediation and psycho-social support is helpful to these children, learning disabilities can adversely effect the kinds of jobs these children will fill as adults and thus their life time earning ability. However, most children with learning disabilities or other mild disabilities will be able to function in society as independent, productive citizens when they grow up.<sup>8</sup> Indeed, many in the group with moderate disabilities and an occasional survivor with severe disability will also meet this criteria for success.

The care for these extremely immature infants is expensive<sup>9,10</sup> and fraught with hazard<sup>11,12</sup>, and prevention of premature birth, where possible, would be preferred to delivery at these extremely short gestations. However, when delivery is necessary or inevitable, the outcome of these infants is far from hopeless.

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All the authors work in the Department of Pediatrics at the University of Mississippi Medical Center. Dr. LeBlanc is a Professor, Dr. Graves is an Associate Professor, and Dr. Rawson is an Assistant Professor. Jenny Moffitt is the nurse who coordinates the Neonatal Follow-up Clinic.

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# Selected Facts About Teen Pregnancy in Mississippi

Marilyn J. Luckett, MPPA

Mississippi State Department of Health (MSDH), Division of Family Planning, USA

F. E. Thompson, Jr., M.D., M.P.H.  
MSDH State Public Health Officer

## I ntroduction

Each day begins a new chapter in the lives of Mississippi teenagers. Many will have their first sexual experience, often coupled with the use of a mind-altering or addictive substance. Some will become pregnant, while others will abort a fetus or give birth. Some will even give birth to their second, third, fourth, or fifth child. Other teenagers will experience a fetal death. Many of these teens will drop out of school. These realities create immediate family crisis and often alter the course of life for both the teens and their families. They also create a social and economic crisis for society.

Mississippi continues to have one of the highest percentages of births to teens in the nation. [More than 20 percent of all live birth babies are born to teen mothers.] The population of girls in Mississippi between the ages of 10 and 19 is 216,145. During the 1997 calendar year, 9,989 teens became pregnant. Those pregnancies resulted in 8,575 live births, 1,264 abortions, and 150 fetal deaths.

These statistics paint troubling pictures. These young mothers are barely removed from childhood themselves. Their education is incomplete; parenting skills undeveloped; and personal potential unfulfilled. The odds are stacked not only against the young mothers but their children as well. These children are the future. One day some of them will sit where policy makers are now sitting, and make decisions that they are now making. These children will attend to those things that society holds dear. Therefore, it behooves policy makers to formulate policies to help shape, direct, and plan for families, communities, and this state. Let's give these children the attention they deserve.—MSDH

### Teen Births by Age and Race of Mother Mississippi 1997

The 8,575 births to Mississippi teens include 3,660 babies born to girls less than 17 years old. Of these 3,660 births, 3,257 were out-of-wedlock, 478 were low-birthweight babies (less than 5.5 pounds), and 388 received inadequate prenatal care. Teenagers are more likely to delay prenatal care and have low-birthweight babies than older mothers.

Age	White	Nonwhite	Total
12	1	11	12
13	7	46	53
14	41	164	205
15	130	434	564
16	343	776	1,119
17	600	1,107	1,707
18	871	1,363	2,234
19	1,105	1,576	2,681
Total	3,098	5,477	8,575

Source — Mississippi State Department of Health Public Health Statistics

### Number and Percentage of Teenage Births by Trimester of Entry into Prenatal Care Mississippi 1997

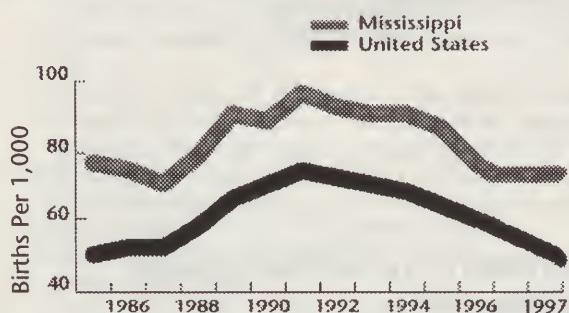
Age	First Trimester	Second Trimester	Third Trimester	No Care	Unknown
17 & Under	2,182 59.6%	1,134 31.0%	235 6.4%	75 2.0%	34 0.9%
18-19	3,468 70.6%	1,119 22.8%	204 4.2%	95 1.9%	29 0.6%
All 10-19	5,660 65.9%	2,253 26.0%	439 5.1%	170 8.0%	63 0.7%

## Trends in Birthrates for Females Ages 15-19

### Mississippi and the United States 1989-1997

The birth rate for females ages 15-19 in Mississippi continues to exceed that of the United States. Although rates have declined slightly yet constantly since 1991, the rate is still much too high.

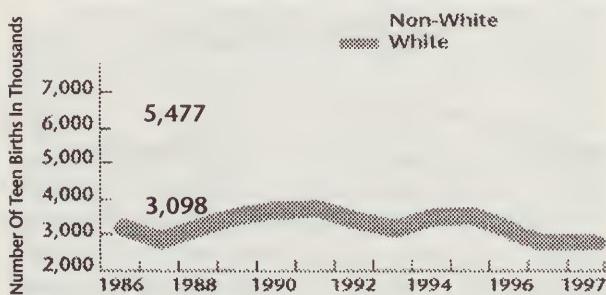
In 1997, Mississippi's birthrate for teenagers 15-19 declined further, dropping from a high point of 86 births per 1,000 in 1991 to 75 per 1,000 in 1997. Comparable national rates began declining at the same rate. Mississippi's teen birthrate remains substantially above the national average.



## Trends in Teenage Births by Race Ages 10-19

### Mississippi and the United States 1989-1997

Until 1988, the number of live births to teen mothers showed decreasing trends for both races from 1970. Current figures show a decrease in live births to teens since 1994 from 9,265 to 8,575 in 1997.



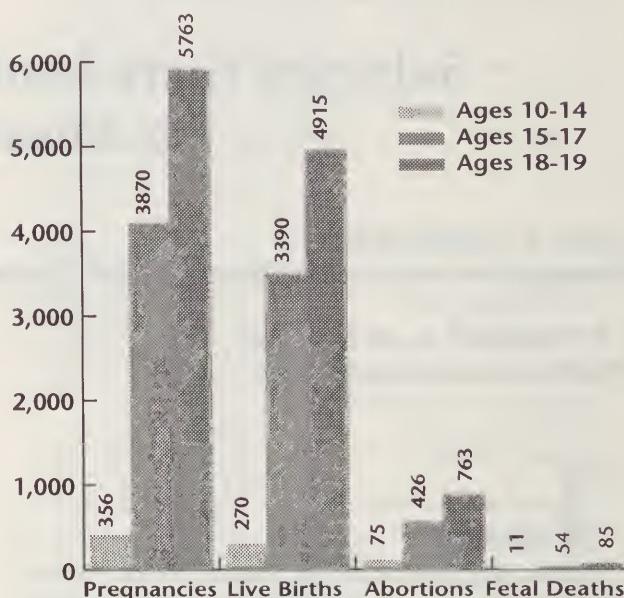
## Number of Teen Pregnancies and Birth Outcomes Mississippi 1997

Pregnant teenagers in Mississippi are more likely to give birth and less likely to terminate their pregnancies than their national peers. National estimates indicate that about one third of all teen pregnancies end in abortion. About 15 percent of Mississippi teens terminate their pregnancies.

Statistics reveal a slight yet constant decline in the number of pregnancies that occur to teens. The number has continually declined from 11,089 during 1992 to

9,989 in 1997.

Pregnancies include births, abortions, and fetal deaths.



## Adolescent Births by Age and Marital Status in Mississippi 1997

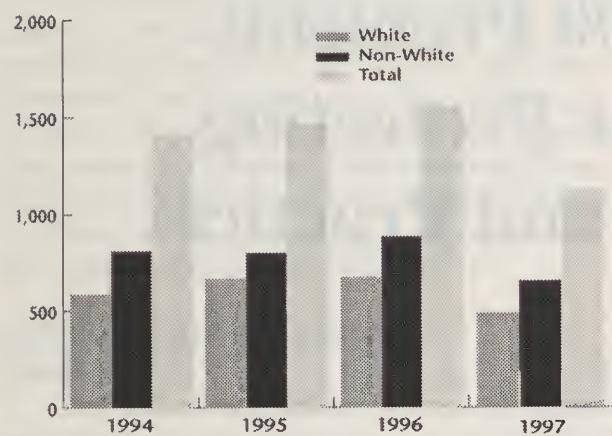
The proportion of single adolescents giving birth is increasing. While the total number of teen births has steadily dropped, the number of births to unmarried teens remained constant, with only slight deviations. Consequently, each year a greater proportion of those teen births has been to unmarried mothers. In 1976, 51.2 percent of teen births were to unmarried mothers. In 1997, unmarried mothers comprised 80.8 percent of the teen births. A significant increase of unwed white mothers prompted this sharp increase. The number of teen births to unmarried white mothers has almost tripled in the past 20 years rising from 615 in 1976 to 1,628 in 1997. Births to unmarried nonwhite teens have risen with slight fluctuations from 5,316 in 1976 to 5,304 in 1997.

Among teens ages 10-17, 89.4 percent (3,257) were single and 10.6 percent (403) were married. Among those teens ages 18-19, 74.2 percent (3,675) were single and 25.8 percent (1,240) of them were married.

## Induced Terminations for Teens by Race

Mississippi 1997

Figures reveal an increase in induced terminations among teens. This is seen among both white and non-white teens.

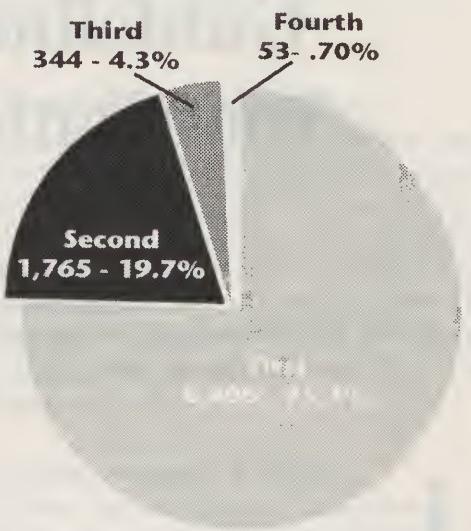


## Live Births to Teen Mothers by Birth Order

Mississippi 1997

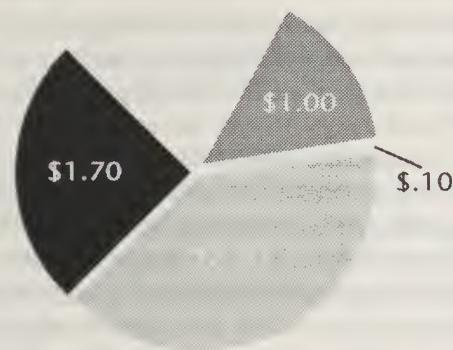
Approximately 25.2 percent or 2,162 of the 8,575 live births to Mississippi teens in 1997 were to teens who had already had at least one previous pregnancy. These births marked the first pregnancy for 6,406, the second for 1,765, the third for 344, and the fourth or more for 68.

These figures represent an increase of .6 percent from last year.



## Cost of Teen Childbearing

Total: 6.9 Billion (\$2,831 Per Teen Parent)  
United States 1996



- Lost Tax Revenue
- Public Assistance
- Health Care
- Foster Care Cost
- Criminal Justice Costs

Source: National Campaign  
To Prevent Teen Pregnancy

APRIL 1999

*The reduction of teen births is a critical public health goal for Mississippi. To reach this goal, we must increase our public understanding of this complicated social problem and develop a commitment for support of education efforts. We must provide social and health services to encourage changes in values and behavior of our youths so they can protect themselves against sexually transmitted diseases and unwanted pregnancies.*

**F. E. Thompson, Jr., MD, MPH**  
— State Health Officer

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# The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice

*[This is the first of a continuing series of excerpts published with permission from **The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice**, published by the American Medical Association, 1999 —Ed.]*

## I ntroduction

Defined broadly, the Year 2000 Problem is the inability of a computer system or other item of equipment utilizing microchips to accurately process date information before, during, and after December 31, 1999. The most prevalent cause of Year 2000 problems is the widespread past practice in the information technology industry of "two-digit date processing." In the 1960's and 70's, when computer memory and processing power were expensive, programmers decided to reduce the storage of dates from eight digits to six digits (eg, the unambiguous date 10/22/1956 was stored as 10/22/56). Computers were programmed to assume that the first two digits of the year always were "19." This convention was adopted almost universally, and utilized in both computer software and in hardware itself. As a result, hardware, software and equipment produced until very recently may not process dates occurring after December 31, 1999 correctly, and calculations using those dates may lead to erroneous results. (Indeed, some hardware, software and equipment being produced even today still contains the Year 2000 Problem.) Another root of the Year 2000 problem is that the year 2000 is a leap year. Leap year calculations can be complex, and require careful programming. Finally, Year 2000-related failures may be caused by the fact that programmers some-

times specified that when the characters "99" appeared in a "field," "special logic" would apply. These characters were often used, for example, to identify the end of a data file or to indicate that a particular item of information had no date associated with it, rather than signifying the year 1999. As a result of special logic programming, problems and errors may occur well before the year 2000.

A broad range of systems and devices may be affected by the Year 2000 Problem. In addition, it is expected that the health care industry will be especially hard hit, due in part to a heavy dependence on technology, as well as the widespread electronic exchange of information. The most obvious potentially affected items are the traditional computer system and computer software programs. In addition to hardware and software, however, problems could be found in many modern devices, because many such devices contain microprocessors embedded in the equipment that control significant aspects of their functionality. Addressing Year 2000 problems created by these embedded systems is one of the most vexing of the Year 2000 related issues. Microprocessors have been built into a multitude of products, from automobiles and facsimile machines to fetal heart monitors, infusion pumps, heart defibrillators, pacemakers and intensive care monitors, just to name a few.

# Year 2000 Compliance Self-Assessment

The following Compliance Assessment can be utilized in evaluating the status of your Year 2000 compliance efforts and to identify areas of potential concern or liability that may have been overlooked or that may require additional attention. It should be modified, however, as appropriate to your organization's own particular needs and characteristics. In addition, it should be utilized only in connection with a complete review of the remainder of the Solutions Manual.

## COMPLIANCE ASSESSMENT

### Objective

This Compliance Assessment identifies the elements of a Year 2000 compliance program that should be included in any Year 2000 compliance plan conforming with legal and industry standards. A check mark in the boxes below would mean that you have assured yourself that not only has each item been complied with, but that in addition your organization has sufficient documentation to establish such compliance.

## BASIC YEAR 2000 COMPLIANCE REQUIREMENTS

### A. Awareness

Has your practice taken steps to assure an appropriate level of understanding throughout the practice of the nature and implications of the Year 2000 Problem?

#### 1. Executive Education/Commitment

Has the management of your practice been informed regarding the nature of the Year 2000 problem and its potential impact on your practice? Is management visible in its support for Year 2000 compliance efforts in your practice?

##### Documentation

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### 2. Employees

Have employees been made aware of the nature of the Year 2000 Problem? Have they been asked for their input regarding how the products, services, or processes for which they are responsible could be affected by the failure of technology or other systems upon which they

rely?

##### Documentation

- Written
- Electronic (eg e-mail)
- Other (Describe)

### 3. Vendors and Business Partners

Have you communicated with your key vendors, payers and others with which you do business regarding the status of their own Year 2000 efforts and their ability to provide uninterrupted products or services after the century change?

##### Documentation

- Written
- Electronic (eg e-mail)
- Other (Describe)

### 4. Future Awareness Activities

Are future awareness and/or information activities planned within the practice or with third parties?

##### Documentation

- Written
- Electronic (eg e-mail)
- Other (Describe)

### 5. Protecting Communications and Identifying Year 2000 Contacts

Have the employees and professionals in your practice been informed of the need to be sensitive to the confidential nature of Year 2000 communications? Is there a single person within the practice designated to receive all inquiries regarding Year 2000 compliance and review all communications from the practice to others regarding the Year 2000 Problem?

##### Documentation

- Written
- Electronic (eg e-mail)
- Other (Describe)

### B. Assessment and Plan Mobilization

#### Objective

Effective assessment of the Year 2000 issues within your practice will include a risk based analysis of how your organization's key products, services, and processes will be affected by the year 2000 and how your organiza-

tion can best address any issues identified.

### **1. Identification of Affected Areas**

Have you identified the business processes, products, and services that could be affected by Year 2000 related problems?

#### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

### **2. Triage**

Have you prioritized your Year 2000 compliance efforts with regard to patient and business processes, products and services that are (1) essential to ongoing operations; (2) create a high risk of harm to others; and/or (3) are likely to fail soon; and have you similarly assessed the degree of risk presented by other affected processes, products or services?

#### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

### **3. Technology Inventory**

Have you performed an inventory of the technology (including computers, medical devices, and other electronic devices or systems utilizing microchips) within your practice? Does that inventory provide sufficient information (ie, model, version, vendor, units in use, status of compliance, risk ranking, interfaces, likely date on which it might fail) to make the inventory a meaningful tool in your Year 2000 compliance efforts? Have you identified technology in all the following categories?

#### **Computer Based**

- Hardware
- Software
- Embedded Systems (particularly medical devices)
- Networks (LAN/WAN hardware and servers, routers, Internet/Intranet servers, e-mail servers, network software)
- Data Security
- Interfaces
- Databases

#### **Environmental/Facilities Management**

- HVAC
- Elevators
- Building Security/ Automatic Timing Devices
- Security Badge Systems
- Fire Control

Sprinklers Controls

Leased Facilities

Food Services

Waste Management

Copy Machines

Postage Machines

Safes and Vaults

Uninterruptible Power Lighting Systems

Parking Access

#### **Telecommunications**

PBX

Centrex

Telephone Systems Software

Faximile machines

Pagers

Cell Phones

Voice-mail

#### **Utilities**

Electric

Telephone

Sewer

Gas

Water

#### **Transactional**

EDI

Direct Deposit

#### **Business Forms**

Checks

Customer/Client Forms

Stationery

Internal Forms

#### **Documentation**

- Written
- Electronic (eg e-mail)
- Other (Describe)

### **4. Adopt a Compliance Definition**

Has your practice adopted a definition of Year 2000 Compliance to be used in connection with its internal compliance efforts and to assess the compliance status of vendors and business partners with which it interacts?

### **5. Documentation**

Have you documented the nature, extent and details of your Year 2000 compliance plan itself?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**C. Identify and Secure Resources**

Has your organization allocated sufficient resources within the practice to address the Year 2000 problem?

**1. Budgeted Costs**

Have you budgeted the costs required for Year 2000 compliance including internal resources, consultants and replacement systems?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**2. Identify Internal or External Sources of Qualified Staff**

Have you identified staff resources, internal or external, to address the problem? Have you taken steps to assure that such staff will be available throughout the project?

**3. Monitor Progress**

Have you taken steps to monitor the progress of the practice's Year 2000 compliance efforts on an ongoing basis?

**4. Retain Appropriate Technical Consultants**

Have you retained the appropriate technical and other consulting services?

**5. Prioritize Business Initiatives**

Have you considered the impact of Year 2000 compliance resource needs on other business initiatives within the practice? Have you deferred other initiatives due to Year 2000 needs where necessary?

**6. Communications**

Have you established a mechanism for collecting and sharing Year 2000 information within your practice?

**D. Development of Testing Plans, and Test Scripts**

Have you defined a testing process to assess whether systems will function properly on, during and after the change in year from 1999 to 2000 and properly calculate leap years? Have testing strategies been developed for hardware, software, medical devices, databases, telecommunications, and facilities?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**E. Remediation Efforts**

Does your practice have sufficient technical expertise to develop a remediation plan for systems requiring conversion, upgrade, or replacement? For any system for which replacement is being considered as a remediation strategy, do you have sufficient time to install, test, and train users on the new system prior to the anticipated failure date of the current system?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**F. Testing**

Does your remediation plan allow appropriate time for testing?

**G. Contingency Planning**

**1. Develop Contingency Plans**

Have you determined:

- a. What your practice will do if particular systems or processes fail entirely or function improperly?
- b. How you will avoid causing injury to others in the event critical equipment components cannot be verified as being compliant prior to any Year 2000 failures?
- c. What trigger dates are required for the effective implementation of contingency solutions?
- d. What duration of failures of mission critical and other business processes will be tolerated before invoking the contingency plan? Who has authority to invoke the plan?

**2. Staffing**

Have you planned for changes in staffing levels that may be necessary due to execution of contingency plans?

**3. Training**

Do you have a plan to ensure that all staff are aware of the contingency plans and are appropriately trained to execute such plans?

**4. Ongoing Update**

Is a process in place to review and update contingency plans as compliance efforts proceed?

*Documentation*

- Written

- Electronic (eg e-mail)
- Other (Describe)

#### **H. Recovery Plan**

Have you considered and documented a "business recovery plan?"

##### **1. Data Backup / Outsourcing**

Does your recovery plan address data backup procedures and the possible outsourcing of backup or recover systems?

##### **2. Staffing**

Do you have sufficient staffing resources available to execute your recovery plan?

###### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **I. Avoid New Problems**

##### **1. Procurement Process**

Does your procurement process require Year 2000 compliance for all new products and services acquired? Have your purchase orders and processes been modified to include Year 2000 warranties and testing?

##### **2. Testing**

Do you test all software systems and equipment for Year 2000 compliance prior to acceptance?

##### **3. Compliance Partners**

Are Year 2000 issues included in your consideration of any significant affiliation, merger, supplier, or other business relationship being entered into by your organization?

#### **J. Vendor Compliance**

##### **1. Create Diligence Trail**

Have you created a paper trail documenting your efforts to identify and avoid Year 2000 problems, including your efforts to obtain information from third parties through vendor compliance inquiries?

###### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

##### **2. Meaningful Information**

Are the responses you are receiving from vendors providing meaningful information including unequivocal

answers regarding the compliance status of their products or services, as well as testing information or other documentation describing the vendors' method of compliance?

#### **3. Other Strategies**

Have you met with your key vendors, payers and others with which you do business to discuss Year 2000 issues?

### **LIABILITY OF CORPORATE DIRECTORS AND OFFICERS**

#### **Objective**

Many physicians serve as directors and/or officers of their professional corporations (or other corporations). Any compliance selfassessment should include an analysis of whether you have satisfied your legal obligations to act prudently and diligently as a director or officer.

#### **A. Director / Officer Education**

Are all persons serving as directors and/or officers educated on the Year 2000 Problem in general, and specifically how it might affect the corporation they serve? Are all such discussions well-documented in the minutes of the Board of Directors?

###### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **B. Ongoing Board Agenda Issue**

Are compliance efforts a regular discussion item at Board meetings?

###### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **C. Regular Reports to Board**

Are those employees or committees charged with day to day compliance efforts regularly reporting to the Board?

###### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **D. Board Ratification of Compliance Plan**

Has the Board considered, modified if and as necessary, and approved a written compliance plan?

###### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

#### **E. Issues In Significant Acquisitions / Relationships**

Has the board ensured that the Year 2000 Problem is included in any due diligence of a proposed merger or acquisition target and any new client, customer, partner, supplier or vendor?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

#### **F. Existing Statutory / Bylaw Protections**

Have applicable state laws and corporate documents been reviewed for the protections currently afforded to officers and directors? Has the company made full use of available protections?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

#### **G. Indemnification Statutes**

Have state indemnification statutes been reviewed to see if they provide protection?

#### **H. Director / Officer Insurance**

##### **1. Maintain Policies / Obtain "Tail" Coverage**

If you are terminating any existing "claims made" insurance policies in the next several years, or if you have done so in the past several years, have you obtained "tail" coverage?

##### **2. Check Coverage**

Have you verified that the desired directors and officers are covered by the D&O insurance policy?

##### **3. Review Exclusions**

Have you reviewed exclusions from the policy to determine whether a claim based on the Year 2000 Problem might fail to be covered?

##### **4. Check Alternative Grounds for Refusing Payment**

Have you verified that the insurer has no grounds to refuse payment under the policy on the basis of misrepresentation(s) in the application? Have all appropriate disclosures been made to the insurer?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

## **CONTRACT AND TORT LIABILITY**

#### **Objective**

The rights and liabilities of the parties to a Year 2000 related dispute will likely be determined by contract and tort law. Your practice should preemptively assess these issues in areas in which failures and resultant disputes are likely.

#### **A. Key Relationships**

Have you reviewed relationships for potential claims by or against your practice? Have you identified entities in the following categories?

- Technology suppliers/vendors
- Business partners
- Government
- Non-technology suppliers/vendors
- Public
- Customers/clients

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

#### **B. Contract Review**

Have you reviewed the relevant contracts with the individuals and entities above to determine potential liability?

##### **1. Identify Liability Areas**

Have you ascertained potential disputes with these individuals/entities?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

##### **2. Collect Relevant Documents**

Has your practice compiled all documents relating to each potential dispute including contracts, any amendments, license agreements, correspondence, memoranda, manuals and other product documentation, marketing materials and brochures?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe) \_\_\_\_\_

##### **3. Conduct Interviews As Needed to Preserve Memories**

Have you interviewed employees with information about the subject matter of the potential dispute and their

recollections of statements made by the relevant parties? Have you considered having memoranda prepared to memorialize such recollections? Have you considered having such memoranda prepared at the request of counsel, in order to preserve their confidentiality?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**4. Review Contracts**

Have you reviewed warranties, disclaimers and limitations on warranties in relevant contracts? Have you assessed any limitations on damage amount or type as well as whether the Uniform Commercial Code applies to the situation? Have you determined if the contract in question provides an effective remedy for or against you?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**5. Identify Potential Insurance Coverage**

Has your practice reviewed its applicable insurance policies to determine if it has coverage for Year 2000 expenses and/or liabilities? (See also the discussion in subpart H. above as to Director / Officer insurance for additional issues that are applicable here as well.)

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**6. Minimize Risk of Harm/Mitigation**

Have you taken all reasonable steps to minimize potential damage to your practice and others?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**C. Tort Liability**

**1. Assess Potential Claims**

With respect to the key relationships identified above, have you reviewed each to determine if there may be a tort claim by or against your practice? Have you considered the following potential claims?

- Fraud and Misrepresentation
- Negligence
- Strict (Product) Liability

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**2. Economic Loss Rule**

Have you or has your counsel considered whether the "economic loss rule" may limit tort recovery for purely economic or business damages (rather than personal injury or property damage)?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**3. Consider Potential Defenses**

In evaluating these claims, have you or has your counsel considered the potential defenses that could be utilized to avoid liability? Have you considered the following?

- Contributory Fault and Comparative Negligence
- Assumption of Risk
- Statutes of Repose
- Statutes of Limitations

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**LICENSE AND COPYRIGHT RESTRICTIONS**

**Objective**

Your ability to test and, if necessary, modify software for Year 2000 compliance may be limited by license and/or copyright restrictions. Prior to such efforts, our practice should determine the extent of any such imitations.

**A. Review License and Maintenance Agreements**

Has your practice identified each potential limitation on its ability to test and modify software and determined if there is any possibility of performing compliance work without breaching the license?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**B. Obtain Consent**

Has your practice attempted to obtain the written consent, if not the participation, of software vendors before modifying their software for Year 2000 compli-

ance?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**C. Permission / Essential Step Defense**

Have you documented all communications with vendors that evidence your efforts to gain their participation in, or consent to, compliance efforts?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**D. Limited Modifications**

Has all testing and modification of the software been strictly limited to correcting the Year 2000 problem?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**E. Patent Issues**

Have you or has your counsel assessed patent issues that may be implicated by compliance efforts?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

## ERISA OBLIGATIONS

**Objective**

Employers and their key employees have a duty to ensure that the company's employee benefit plans will continue to function properly into the next century. Any self assessment should include a review of these efforts.

**A. Catalog Plans and Computer Systems**

Has your practice compiled a list of all of your organization's retirement and benefit plans? Have you made a list of all computer systems (including those of outside vendors) needed to operate the plans?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**B. Hard Copies**

Has your practice developed plans for making hard

copies of all plan data at the first sign of Year 2000 computer malfunctions, and in any event in December 1999?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**C. "Blackout Period"**

Have you considered working with pension plan investment advisors to develop a "blackout period" investment strategy (ie, to put plan assets in temporary investments not susceptible to Year 2000 problems well in advance of the change of century and for the first several months of the Year 2000)?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**D. Plan Contingency**

Have you developed contingency procedures for carrying out plan functions until all Year 2000 problems have been remedied? For health plans, have you developed or ensured that your vendor has developed contingency plans for manually verifying coverage and providing necessary treatment authorizations?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

**E. Plan Insurance Policies**

Have you reviewed your plan's fiduciary insurance policies, if any, to ascertain whether fiduciary liability caused by an inadequate response to the Year 2000 problem is covered?

*Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

## INSURANCE COVERAGE ISSUES

**Objective**

Your practice could face substantial costs associated with achieving compliance within your organization, and with potential legal liability to third parties. Many of these costs and/or incurred liabilities could be deemed insured losses. As a result, your selfassessment should include a review of insurance policies.

#### **A. Policy Audit**

Has your practice examined policies to determine if coverage exists for Year 2000 expenses and/or liabilities?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

Other (Describe)

#### **B. Notice Requirements**

Has your practice reviewed existing policies to identify any time constraints for making claims and any applicable limitation periods for bringing a lawsuit to contest an insurer's coverage decision?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **B. Communications With Outside Consultants**

Have you considered retaining, and communicating with, your outside consultants through an attorney, to help keep those communications privileged?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **C. Prevent Exclusions**

In negotiating with insurers, have you attempted to prevent them from adopting Year 2000 exclusionary language?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **D. Identify Existing Exclusions**

Has your practice reviewed current policies to determine if Year 2000 exclusions exist?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

#### **C. Electronic-Mail / Internet**

Has your practice taken reasonable precautions to protect sensitive information conveyed via e-mail? Have you informed employees that discussing privileged matters in online discussion groups on the internet would likely waive the privilege and is not allowed?

##### *Documentation*

- Written
- Electronic (eg e-mail)
- Other (Describe)

For practical answers to Y2K questions, and a variety of useful resources and Web links, please visit the AMA Y2K Web site at <http://www.ama-assn.org/not-mo/y2k/index.htm>.

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#### **AMA Members May Download Free Copy of Important Y2K Publication**

*The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice* is hot off the press and ready to assist physicians in their preparation for the year 2000. The manual provides an overview of the issues and raises physician awareness of the potentially devastating operational and financial implications of failing to understand and address these issues within their practices. Some of the topics include: liability of corporate officers and directors, legal fundamentals, insurance coverage, medical equipment and payment/billing issues. The 73-page publication contains more than 26 "practical tips" for physicians to apply during their own compliance process.

AMA members may download the entire document from the AMA Web site at <http://www.ama-assn.org/not-moly2k/protguid.htm>. The publication can be ordered by calling the Customer Service Center at (800) 622-8335. The cost of the publication is \$25 for AMA members, and \$100 for nonmembers.

## **COMMUNICATIONS PROTOCOLS**

### **Objective**

Any compliance effort will likely lead to sensitive, self-critical assessments that may be damaging in litigation if not protected from discovery. Your compliance efforts should include efforts to protect such communications from disclosure.

#### **A. Protect Confidential Communications**

Have you proactively attempted to protect confidential communications with the attorney-client privilege, or the attorney work product doctrine?

##### *Documentation*

- Written
- Electronic (eg e-mail)



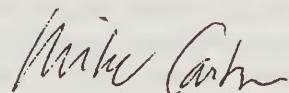
**Michael H. Carter, Jr., M.D.  
The President's Page**

## **Are You Ready?**

**“R**eady or not, here it comes.” That’s the message from computer gurus across the nation about the year 2000. According to news reports, physicians are not adequately preparing for the day when glitches could wreak havoc on computerized payment systems and patient networks. This is being touted as such a big problem that physicians may be caught behind the curve if we aren’t already making plans for compliance with the technical side of the Y2K issue as well as the legal liability.

Many physicians seem unaware that they need to take positive action to address Y2K readiness. Armed with their stethoscope and otoscope, these doctors believe that if they take care of their patients, Y2K will take care of itself. It is not enough to rely on vendors and payors to see that clinical operations will continue smoothly, that medical equipment will hum into the new year or that electronic claims can be processed without a glitch. We must actively assess our practice and our processes to be sure that we can continue to practice medicine with as little interference and interruption as possible.

If you haven’t already, now is the time to take a serious look at the “millennium bug” and ways to protect your practice and your patients. There is a lot of information out there to help doctors conduct an internal inventory of their practice and avoid processing failures that would slow payment streams from government programs and private payors. This is one bug that physicians will not want to catch.

A handwritten signature in cursive ink that reads "Mike Carter".

# A Message from HCFA

January 12, 1999

Dear Health Care Partner:

You have probably heard about the Year 2000 computer problem, or the "Y2K bug." As a health care practitioner or institution, you need to be aware of how Y2K affects you and your patients. We all must do our part so that Medicare and Medicaid beneficiaries continue to receive high quality care, and you or your institution continue to be paid accurately and promptly.

The Year 2000 problem appears simple on the surface. Many computers and devices use only six digits to record dates. They may read 01-01-00 as January 1, 1900, rather than January 1, 2000. Patient care services, systems, and devices that rely on dates, the age of the patient, and other calculations could be severely affected if corrections are not made in time.

Every business and organization that relies on computer systems or devices must address Y2K. For all of us in the health care industry, it is a patient care issue as well as a business and technical problem. As Administrator of the Health Care Financing Administration (HCFA), I need to make sure you are aware of some key points:

HCFA will be ready to process acceptable claims. We have made substantial progress in correcting our own systems in recent months and, despite earlier concerns, we will be ready on time. "We are confident that all Medicare claims processes will be ready and able to function come January 1, 2000, so that you can be paid promptly.

You must also be ready if you wish to be paid promptly. We can process your claims only if your systems are also able to function in the Year 2000. It is URGENT that you act NOW so your systems will be ready. Otherwise, you may not be able to receive prompt payment from Medicare, Medicaid, and virtually any other payer.

Your entire practice and facility must be ready. The Y2K problem could impact quality of care and patient safety. Patient management systems, clinical information systems, defibrillators and infusion pumps and other medical devices, even elevators and security systems all must be ready.

We want to help you prepare for the Year 2000. The following is a "Sample Provider Y2K Readiness Checklist" which you can use to assess what you need to do. You can find additional useful information at the HCFA web site. Information on medical devices is available on the Food and Drug Administration web site.

We are confident that HCFA will be ready, but we are also making contingency plans so we can continue operations if unexpected problems occur. For those of you that rely on computer systems, we believe the greatest risk is that your systems will not be able to bill for services.

You need to make sure you will be ready for the Year 2000. And, like us, you need to make contingency plans for your critical operations. These should focus especially on assuring safety for your patients who are reliant on equipment and devices containing embedded chips. In addition, you need to assure your ability to generate bills and manage accounts receivables, and assure essential services and supplies are maintained.

Your patients and your business may depend on this.

What can you do to avoid potential Y2K pitfalls? There are key steps you can take to become Y2K ready:

Be aware of how the Year 2000 can affect your systems. Anything that depends on a microchip or date entry could be affected. Don't forget to identify those organizations that you depend on or who depend on you. List everything and identify your mission critical items, namely, those you cannot live without.

Assess the readiness of everything on your list. You can do this by contacting your hardware or software vendors or accessing key information from various web sites. Don't forget your maintenance and service contractors. If your particular software program or form is not Y2K ready, you need to decide whether you should invest in an upgrade or replacement.

Update or replace systems, software programs, and devices you decide are critical for your business continuity.

Test your existing and newly purchased systems and software. Do not assume that a system or a program is Y2K ready just because someone said it is. Test to make sure. During this process, keep track of your test plans and outputs in case a problem surfaces later. If you are not already using compliant electronic claim formats, consider testing your electronic data interchanges (EDI) with one or more of your payers, including Medicare. This will ensure that your payer can accept your EDI transactions, especially claims. Medicare can now accept claims with eight digit date formats.

Develop business contingency (continuity) plans in the event something goes wrong. Focus on the things that would be most problematic for you and your patients.

The Y2K Readiness Checklist may also helpful. It is only meant to be a guide and should not be considered all-inclusive.

Medicare beneficiaries are counting on all of us to meet the Year 2000 challenge. We will be ready. Now you need to do your part to be sure that you will continue to be paid as beneficiaries are assured that they will continue to receive the health care they have come to depend on.

Sincerely,

Nancy-Ann DeParle  
Administrator of the Health Care Financing Administration



## NANCY O'NEAL TATUM, 1950 - 1998: A BEAUTIFUL, BLESSED LIFE

*"To prevent disease, to relieve suffering and to heal the sick—this is our work."*  
*Sir William Osler*

The first aphorism of Hippocrates warns physicians that "Life is short, the art is long." He is right. In this life there is so little time, and this we learn often so painfully, as when we lose someone dear. Nancy O'Neal Tatum, 48, of Jackson, an associate professor of family medicine at UMC, died suddenly of cardiopulmonary failure following surgery to remove a mediastinal mass at Mississippi Baptist Medical Center on Wednesday, November 25, 1998. She lived a beautiful, blessed life, touching countless lives both professionally and personally. To the MSMA, her leadership will be missed in no small way. At the time of her death she was a member of the MSMA Board of Trustees, Alternate Delegate to the AMA, and co-chair of the Joint Practice Committee. Her longtime friend and department chair, Dr. Lessa Phillips, calls Nancy "a great inspiration" to both her students and her faculty colleagues. "She never lost her focus on the patient as the most important factor in the doctor-patient equation," says Dr. Phillips. "She exemplified everything noble about our profession," Phillips concludes.

Nancy's life had always been a blessing to others from the time of her birth almost a half century ago in Hattiesburg's old Methodist Hospital. She grew up a Tatum in Hattiesburg, quite a family of which to be part in the Piney Woods. There is a saying in the Piney Woods that one can walk from Hattiesburg to Gulfport and never let a foot leave Tatum land. Her great grandfather, Willie Sion Franklin Tatum (1858-1949), one of the South's pioneer lumbermen, was a native Tennessean who with his brother-in-law M. F. O'Neal established a lumber business in Hattiesburg in 1892, in the heat of the longleaf pine boom in the Piney Woods. He soon owned the entire mill and became one of south Mississippi's wealthiest men. He was the principal benefactor of Main Street Methodist Church during his lifetime, was the leading push behind the establishment of Hattiesburg's Methodist Hospital, and he even established in the early part of this century a hundred thousand dollar endowment for a Tatum Chair of Religious

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

Studies at Millsaps College. He founded a Hattiesburg bank, the Bonhomie and Hattiesburg Southern Railroad, and an oil and gas company. He served as Mayor of Hattiesburg for three terms.

Despite this family wealth, she never showed it, and never lost her humanity nor had any obsession of money. Her father's occupation as a physician probably did serve to ground her in ways unknown to both and teach her to seek out the downtrodden. Her childhood in other ways was a typical one for South Mississippi, and she loved music, science, her church, and life.

Mike Gandy of Ridgeland was a childhood friend. He remembers that her singular spirit and zest for life were there all along and recalls: "My favorite memory, though, is a typical Nancy moment, probably dating back to her teen years. I was at a friend's house when he yelled, 'Look at that!' I ran to the window in time to glimpse Nancy Tatum riding a unicycle down O'Ferral Street. She's not merely the only person I've ever known that could ride one, but the only one who would take the time and have the sense of whimsy to learn such a skill."

In 1968, she graduated from Hattiesburg High School and entered the University of Southern Mississippi. There she followed her passion for music, obtaining a B. A. in Music Education in 1972, after having served as President of the Association of Women Students and of the Student Government Association. Her innate leadership qualities were obvious even then. "She was a Southern lady," says friend Bill Thompson, "well mannered and refined without being snobby, with traditional core values."

Following her graduation, she directed and taught choral music at Hattiesburg High School for three years. Her longtime friend Gandy recalls how he enjoyed "seeing the joy she took in sharing what she knew about music." Gandy says: "She had such an infectious enthusiasm about a full range of subjects. During my student teaching days, she said, 'Hey, you know *Rustles of Spring*? Listen to this!' And she sat down and played it flawlessly. Years later I ran across the sheet music. It was, of course, impossible. But not for Nancy."

Her love of music and teaching spilled over to Hattiesburg's Main Street United Methodist Church, where she directed the youth choir. Gandy recalls further: "The night when Hurricane Camille was coming, she was directing a youth choir rehearsal in the old choir room on the second floor at Main Street. We weren't doing so good, mostly due to looking out the window at the wind whipping the old pear tree. Finally, exasperated, she grabbed the music stand and said, 'Okay already, the hurricane's coming. And it'll probably blow us all away. But not before we get this passage right!' And we all loved watching her direct. She'd get so into the music that she'd kick her head on the third beat while sweeping her hands outward. We kidded her about it, so she did it twice as hard."

Despite this deep passion for music, Nancy decided after these three years of teaching to go back to school and considered a career change. Her love was for science and music and people. She realized that to make a living in music, she would need more education, a master's degree or more, and teaching music did have its frustrations. She thought that if she had to return to school, why not go to medical school? Her doctor father had not pushed her towards medicine, although his example was powerful.

So she returned to her beloved USM for undergraduate pre-medical requirements. (She was forever a USM fan, and I remember her car sported a USM emblem. She even served a term on the board of directors for the USM Foundation.) And soon she was in medical school in Jackson at the University of Mississippi Medical Center, where she earned her M. D. She stayed in Jackson to complete her residency in family medicine. While there, she was chief resident and received the George Lally Bevill Award. She continued to love Hattiesburg, and as her close friend Dwalia South recalled in her fine remembrance in the February MSMA journal, Nancy loved her family and home, and seldom missed an excuse to head there for the weekend.

After finishing her residency in 1983, Nancy joined her father's practice in Petal, Mississippi, which is just outside of Hattiesburg, and at that time, the two were the only father-daughter team practicing in the state. Her father, Dr. A. T. "Deet" Tatum, had opened his medical practice in Petal in 1949. Upon her arrival, there were three Tatum physicians practicing in the Hattiesburg area, and in the small town tradition, the three Tatum doctors were not called Drs. Tatum, but rather "Dr. A. T.", "Dr. Nancy", and "Dr. Fred"(A. T.'s brother, a cardiologist).

A country doctor who still made housecalls, the elder Tatum worked from a desk which had been specially made for clinical examinations. It was a fascinating and gargantuan wooden desk with a built in chair for the patient. In this environment, he was often called "one of the last of a breed" of the old fashioned family doctors. Nancy's arrival as a partner proved difficult in some ways for her. Her father placed her on barely a subsistence wage (less than minimum wage she maintained). She complained that she thought he was trying to starve her to death, and he felt he was overpaying her. She soon discovered that the practice lost money in a big way and did not even send out

bills to the patients. And her father never asked the patients for money. (However, he did threaten that upon his death, he would require his open casket to be placed at the intersection of Central Avenue and Main Street to receive payments until all accounts were paid in full.) Basically his inherited wealth subsidized his medical practice, and all his sweat was not for pay but for love of his patients and the practice of medicine. What a man! How many of us would practice medicine the hours we do if it *costs* money? I can still hear Nancy laugh about how many patients complained and left after she initiated a formal system of billing so she could at least make a minimum income.

Besides the pay, the generational gap proved interesting for both doctors. Soon after starting work with Dr. Deet, Nancy was asked by her father to suture a patient's wound at the clinic in Petal. "Where do you keep the sterile gloves?" she asked. He told her to just wash her hands well. She remembered, "My daddy never used sterile gloves."

Her practice of medicine in Petal was an important job and one that she did well. Says friend Mike Gandy, "What a gift of compassion Nancy had. She wore the mantle of being a Dr. Tatum well and was a worthy successor to her father." One of her friends and patients, Dr. Bill Thompson relates: "As a patient I was never afraid to come to Nancy for anything. She never took away your dignity nor humanity no matter what you said or had done. She took time with you. She was not judgmental, but as a physician she was not afraid to tell the hard truths of any medical condition or situation. And she was always on your side as a patient 100%. As a physician, she was a living saint."

Her interests in the Hattiesburg area focused on her Methodist faith, her music, and later her work as a local leader in the battle against HIV and AIDS. Reverend Andy Johnson, a Methodist minister who worked with her at USM's Wesley Foundation(a Methodist student ministries program), knew her during her service as director of the student choir. He remembers: "In Nancy's eyes, no one was too unimportant or too important. She challenged those of us around her to think of those who were hurting and those who needed our caring. I could count on Nancy to tell me what I needed to hear, even if it hurt, to make me a better person." Their associations in the Methodist church further revealed parts of her character. He says, "Nancy was genuine always. When you interacted with Nancy, you got Nancy and no facade."

It was in Hattiesburg in the middle 1980s that the plight of patients with HIV first attracted her attention. She saw a need and stepped up. In this fairly conservative area of South Mississippi, she was founding president and chairman of the Hattiesburg Area AIDS Coalition, called "HAAC." With fellow organizers Kathy Wall and Amy Adelman, Nancy created in 1988 one of the most important AIDS Coalition groups in the South, bringing both the liberal and conservative parts of the community together to battle AIDS and support its victims. "It did a lot of good work," says fellow volunteer Bill Thompson. He continues: "Nancy framed a compassionate and humanistic response to AIDS in a conservative community that was not initially receptive to the social stigmas often associated with the disease. And she was largely responsible for the group's success." While she was president of the group, a piece of the AIDS quilt first came to Mississippi, and that place was Hattiesburg. Conflicts arose in the organization, and Nancy, says Thompson, was the "calming influence to see us through the storm." However, he stresses her intellectual courage: "Nancy was not afraid of a fight if necessary, but she did not go looking for one."

At the local level, her cause influenced her practice. She became the medical specialist with AIDS in the community, with HIV patients flocking to her and physicians referring their AIDS patients to her. She never turned a patient away and would treat patients whether they could pay their bill or not. "She never took away any patient's dignity," says Thompson. He notes that she would work hard to find ways her HIV patients could obtain their medications, and often paid for these medicines out of her own pocket. He remembers her diligence after the death of an AIDS patient to gather up the unused medicines to give to patients who could not afford them.

Following her father's death of cancer in 1992, Nancy made the difficult decision to leave her private clinical practice and make a great leap: she completed a year of post-doctoral work as a visiting scholar at the Center for Clinical and Research Ethics at Vanderbilt University in Nashville. It was a daring decision, as well as an emotional one. She loved Hattiesburg and her work there. But she yearned for the challenge and opportunity to teach. As well, she had been heavily recruited by UMC's family medicine department for years. Teaching medicine combined two of her great loves and her two past careers: medicine and teaching.

Her work in ethics brought her back to Mississippi, but not to Petal, but rather to the bigger stage of Jackson. Her family's past and her own work as a physician positioned her to do great things for Mississippi, exerting an influence here unlike she could in any other state or place. Her leadership would center on ethics development, AIDS support and education, and restoring the primary role of family medicine in an academic environment which often threatened the nonspecialist. She had served as a clinical instructor and as a preceptor in family medicine during

her private practice, and she would now go at teaching full time, joining the staff of the Department of Family Practice at UMC in Jackson in 1993 as an associate professor and attending physician. In addition to teaching duties with the family practice residents, Nancy was chiefly responsible for establishing UMC's formal ethics program. Her efforts included the pursuit of continuing education on ethical issues and serving on UMC's ethics advisory committee, whose members were available to both staff and patients. I was one of her students, and she was one of the finest instructors I have ever witnessed. Others saw this too and in both 1994 and 1998, Nancy received the family medicine department's Golden Stethoscope Award as the students' choice of best teacher. In 1996, she was a visiting scholar with the Harvard Macy Program for Physician Educators in Boston. She completed certification in medical ethics at the University of Washington in Seattle during the summer of 1998. During the last few years, she published several book chapters and journal articles on various medical topics. She was highly respected among all of the physicians at UMC.

In Jackson, she maintained her Methodist traditions, joining Galloway Methodist Church, and she continued her work with HIV and AIDS patients in the area. I talked at length with her about every one of my practice's HIV patients, and she was ever tolerant of my many questions regarding up to date drug and treatment protocols. She never stopped teaching us, even after we left the residency program. She seemed to love her life in Jackson, and she and Anne McWilliams purchased a beautiful house on Greenbriar Drive in Jackson's Eastover neighborhood.

Professionally, the department of family medicine at UMC experienced changes and evolutions during her tenure there, which were often difficult for staff, residents, and students. One of her fellow professors described her as the "unanxious presence" in the heat of departmental discussions, always the calming influence, asking others by example to appeal to the better angels of their nature. She was a popular leader at the department's West Jackson Clinic on Chadwick Drive, and at the time of her death, was serving as Clinical Director.

Motivating her teaching was concern about the devaluation of the family physician in a growing world of specialty emphasis. Her interest in teaching both medicine and ethics encompassed the personal aspect of primary care, which is what she felt made family medicine so special. As a student and resident under Nancy, I can attest she was not only kind, but loving always, and full of humor. She seemed to look for ways to nurture her students and encourage them on a personal, individual basis, usually by example. I recall her smile after I yanked her out of bed at 2 a.m. to assist me in my workup of a difficult hospital admission. And I remember my attempts to get the job done as quickly as possible, and her gentle and diligent patience with the case, despite the wretched hour. I try to remember that now when I am called out of bed at 2 a.m. with a difficult patient.

She confronted death with the same courage she had confronted all of her difficult battles of life. In the end, she was still the healer, death could not take that from her, and she made efforts to heal those of us who loved her, sending letters and emails and preparing a therapeutic and elegant funeral at good old Main Street. I still can not believe Nancy is gone. But her *art*, and her healing life, endures.

After her death, friend John McVay wrote to Nancy's family: "You see, I recognized and appreciated a couple of things in her that I will miss most: 1) her willingness to step up and assume responsibility to get stuff done, (when so many lazy, apathetic 'spectators of life' like myself depended on people like Nancy to be concerned and see that the job got done) and 2) her readiness to 'give a care' as a care-giver." Her patient and friend Bill Thompson relates: "Nancy was not afraid to change and grow. She was on a journey and never would stop growing and being open to change. For all our differences, I admired her and wanted to be like her. I wanted to be able to lead and talk to all different kinds of people and bring them together like she did. She was a role model for me." The medical school's Class of 1999 Evers Society, a student group which recognizes excellence in teaching throughout the four years of their class, dedicated a memorial to Nancy to be placed in the Department of Family Medicine.

My last memory of her is of a chance meeting at a conference, and though both of us were hurried, her innate thoughtfulness lifted my spirit as it always had. Mississippi has lost a noble servant, but I, and those of you who knew her, have lost a beautiful friend, intelligent, kind, gallant, warm, generous, and witty. She was such an inspiration and so much fun to know. A joy. Her life's motto was Walt Whitman's great line, speaking of an outcast: "Not until the sun excludes the earth will I exclude you."

Everyone whose life she touched was the better for it. Anne McWilliams passed along in one of our exchanges of letters a poem by W. H. Auden called *Funeral Blues*. It sums up our great loss of a one of a kind friend better than anything I could write. It follows, with a few poetic liberties taken by Anne:

*"Stop all the clocks, cut off the telephone,  
Prevent the dog from barking with a juicy bone,  
Silence the pianos and with muffled drum  
Bring out the coffin, let the mourners come.*

*"Let aeroplanes circle moaning overhead  
Scribbling on the sky the message She is Dead,  
Put crepe bows round the white necks of the public  
doves,  
Let the traffic policemen wear black cotton gloves.*

*"She was my North, my South, my East and West,  
My working week and my Sunday rest,  
My noon, my midnight, my talk, my song;  
I thought that love would last for ever: I was wrong.*

*"The stars are not wanted now: put out every one;  
Pack up the moon and dismantle the sun;  
Pour away the ocean and sweep up the wood;  
For nothing now can ever come to any good."*

God bless you, Nancy.

— **Lucius Lampton**  
*Associate Editor*

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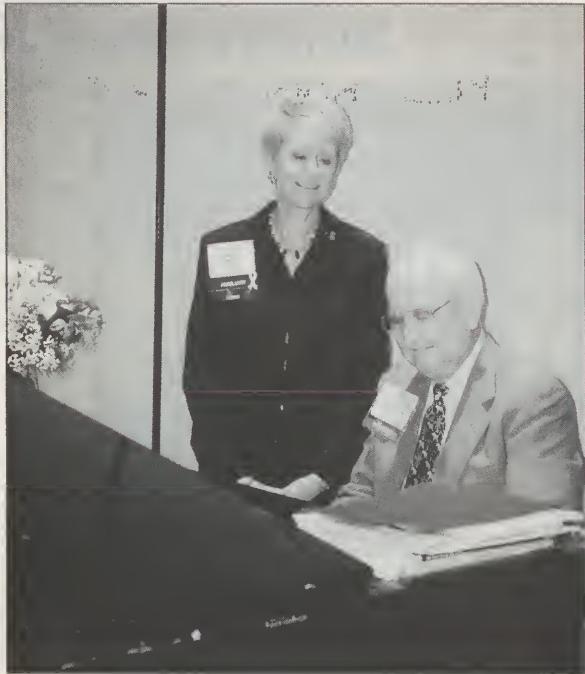
## MSMA Alliance



Vice-Chancellor of the University of the Mississippi School of Medicine, Wallace A. Conerly, M.D. welcomes MSMA and Alliance members to an Ole Miss Alumni reception held during the Southern Medical Association meeting. (left to right) Dr. and Mrs. Dewitt Crawford, Dr. and Mrs. Ben Carmichael, Dr. Conerly, Dr. and Mrs. Lee Rogers. (seated) Dr. and Mrs. Eric Lindstrom.



The MSMA Council on Medical Services met at Lake Tiak-O-Khata in Louisville to develop Practice Guidelines for Physicians in Collaborative Practice. These guidelines will be presented to the MSMA delegates at Annual Session. (left to right) Joe Ross Jr., M.D., Chair; Frank Bowen, M.D.; Peggy Crawford, Alliance representative; Dewitt Crawford, M.D., guest; Glen Peters, M.D. and Alfio Rausa, M.D.



(left to right) Our thanks to the Alliance "Musician in Residence", Dr. Ben Carmichael of Hattiesburg for entertaining us on numerous occasions. His wife, Kathy, assists by turning pages.



Susan Rish (left), president-elect, Lee County Medical Alliance for 1998-99 brings supplies to the SAFE Shelter director. This is an on-going nation wide SAVE (Stop America's Violence Everywhere) project of the Alliance members.

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## MSMA and MSMA Alliance Host AMA's Superhero "The Extinguisher"

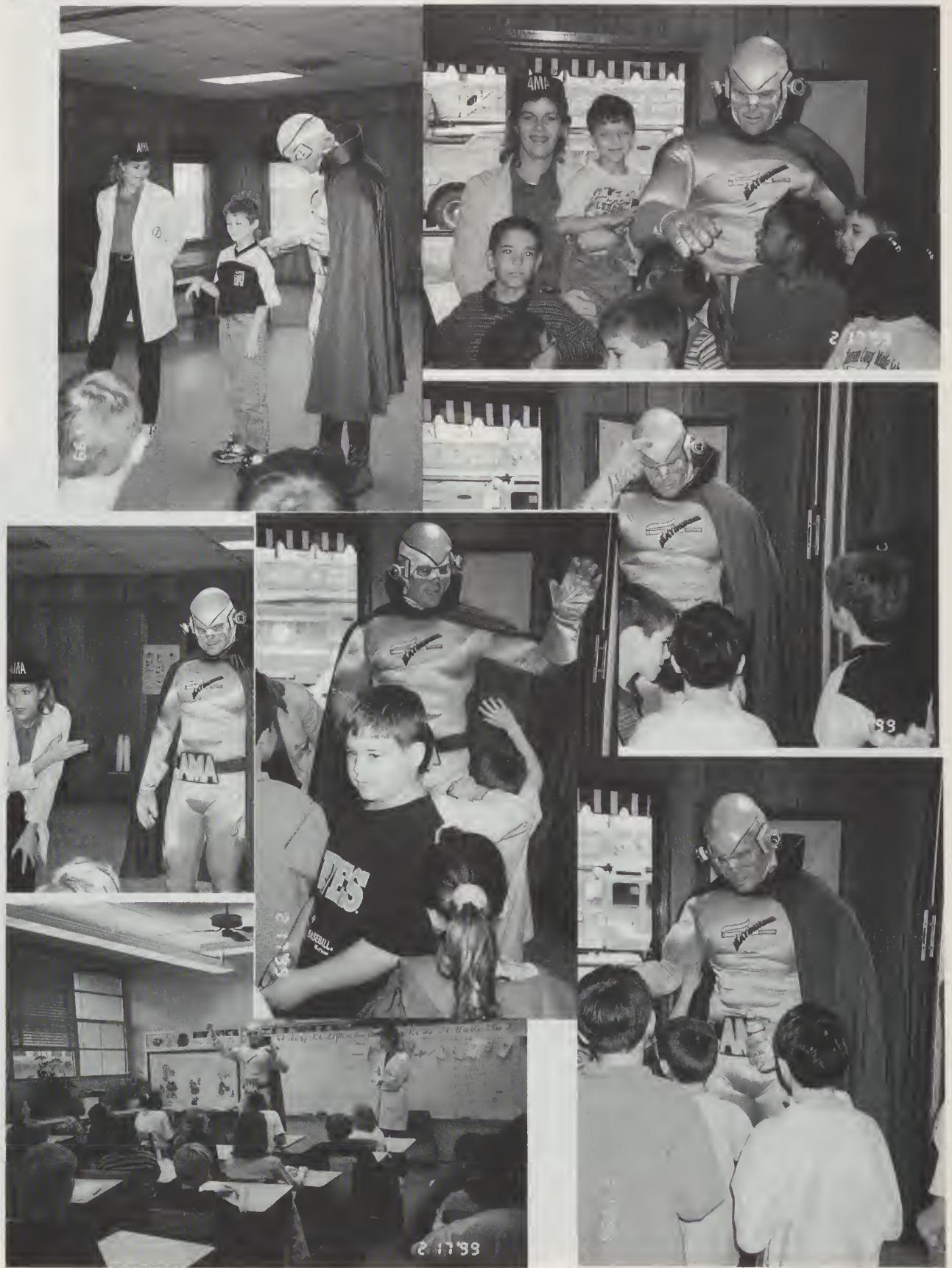
MSMA and the MSMAA sponsored AMA's cartoon superhero, "The Extinguisher," and his mentor and creator, "Doctor Nola Know" to take the two champions for America's kids in the fight against tobacco to schools in Vicksburg and Tupelo. Their mission was to educate and protect children from the dangers of smoking. Together, they helped kids wage their own "kid crusades" to "smoke out" and "extinguish" the cigarette industry's advertising and marketing campaigns targeted toward America's youth. The super duo is part of the AMA's nationwide public health campaign aimed at teaching elementary school-age children about the dangers of smoking and nicotine addiction. The AMA's Extinguisher and Dr. Know, played by Susan A. Chiarito, M.D. of Vicksburg and Katherine Pastrell, M.D. of Tupelo, appeared at anti-smoking events.



*Thank you to the Vicksburg Fire Department for helping stage a dramatic entrance for "The Extinguisher." Assisting "The Extinguisher" is Susan A. Chiarito, M.D. of Vicksburg.*



*John White plays "The Extinguisher."*



## **Information and Quality Healthcare Update**

An area newspaper recently requested a news story from I.Q.H.; a critiquing editor described the release as "self-serving." It was soon determined that what the editor really wanted was a byline article concerning the I.Q.H. role in the health care scene, along with possible answers to health care delivery questions that the nation has been facing for several years. It was easy enough to switch gears and write a first-person opinion-editorial explaining the challenges of working as the Mississippi PRO/QIO to favorably impact the quality of care delivered to Medicare beneficiaries. The article noted that the strategy planned by the Health Care Financing Administration(HCFA) may well serve as a guide to bringing about effective changes in health care delivery.

As the largest purchaser of health care in the country, HCFA has determined to take its role further. In addition to buying the health care for an estimated 70 million persons, HCFA has formulated specific plans in an all-out effort to ensure improvement in the delivery of cost-effective, appropriate, high quality health care for all its beneficiaries. The intent of promoting and presenting beneficiary rights and protections and meeting the highest standards of performance is foremost in HCFA's innovative strategies. The idea of fostering excellence in the design and administration of all the HCFA programs is also a priority.

Whether written in third person or first person: when we at I.Q.H. tell about the role we play in assuring quality

health care, it can indeed sound 'self-serving.' The fact that we have this important story to tell certainly seems to be non-self-serving, particularly since I.Q.H. is a non-profit organization. Staff members are dedicated to telling about the role of I.Q.H. in order for beneficiaries, physicians and providers to be aware of its work and to be a part of this vital program. If we don't share this work through letters, newsletters, the media and any other possible means short of skywriting, we will be limited in achieving our goal of impacting the delivery of the best possible quality of care.

The I.Q.H. work with Medicare beneficiaries might sound self-promotional, as we tell of dedicated staff members who carry out their work of monitoring quality concerns. Duties also include responding to a variety of concerns and questions on the telephone hotline. Providing programs at no cost to any group in the state takes staff members to every region, presenting vital information to hospital-sponsored senior organizations, at libraries, churches, malls, and club meetings.

Explaining how I.Q.H. collaborates with physicians and health care providers in the Health Care Quality Improvement Program (HCQIP) might sound self-enhancing, but the fact is I.Q.H. serves as the catalyst or the motivator in this ambitious undertaking. Any glory in the HCQIP partnerships and collaborations goes to the participants in these efforts to continuously improve the quality of care for beneficiaries. Without the collabora-

ing hospitals, their enthusiastic staff members and the support of the physicians in the state, the HCQIP work would not be possible.

A recent survey about the Health Quality Improvement Programs nationwide reflected lives saved and costs reduced. This first national report on the programs designed to improve the health care provided to seniors shows that quality improvement programs have increased access to appropriate care, have reduced deaths and often led to cost savings.

The report released by the American Health Quality Association composed of all the PRO/QIOs in the nation is entitled "A Pillar of Quality; The Medicare Peer Review Organization/Quality Improvement Organization." It showcases the results of 498 projects conducted across the nation in hospitals and HMOs from April 1, 1996, through March 1998. Thirty-five quality improvement projects

have been conducted by your Mississippi PRO/QIO since the beginning of the Health Care Quality Improvement Program in 1994.

The local collaborations and partnerships with hospitals, health plans, providers, community coalitions and others to assess and improve quality in Medicare clearly demonstrate that continuous quality improvement can motivate change in the health care system and provide positive outcomes.

We will be providing "Pillar of Quality" reports to the I.Q.H. Board of Directors. Anyone interested in reading this report can contact I.Q.H. to receive a copy. If we sound self-serving, so be it, but we want to share these important messages with any interested persons.

—James S. McIlwain, M.D., I.Q.H.  
President, Principal Clinical Coordinator



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# New Members

**ASKEW, EDWARD, III,** Hattiesburg. Born February 21, 1962; MD Louisiana State University School of Medicine, New Orleans, LA, 1988; internal medicine residency, Ochsner Medical Foundation Program, New Orleans, LA, 1988-91; elected by South MS Medical Society.

**ATKINSON, THEODORE E., III,** Hattiesburg. Born Atlanta, GA August 3, 1955; MD University of Mississippi School of Medicine, Jackson, MS, 1980; pediatric residency, Letterman Army Medical Center, San Francisco, CA, 1980-83; development-behavioral pediatrics fellowship, William Beaumont Army Center; 1986-88; elected by South MS Medical Society.

**CALCOTE, VICTOR I.,** Pascagoula. Born El Dorado, AR, Nov. 13, 1952; MD University of Arkansas Medical School, Little Rock, AR, 1985; interned & pathology residency, Baylor University Medical Center, Dallas, TX, 1985-90; elected by Singing River Medical Society.

**CARR, WILLIAM C.**, Starkville. Born Atlanta, GA, April 18, 1965; MD Rush Medical College of Medicine, Chicago, IL, 1992; general surgery internship, Loyola University Medical Center, Maywood, IL, 1992-93; otolaryngology residency, Univ. Of Illinois Medical Center, Chicago, IL 1993-94; internal medicine residency, Illinois Masonic Medical Center, Chicago, IL, 1995-98; elected by Prairie Medical Society.

**CARROLL, DAVID R.,** Ridgeland. Born Grande Prairie, TX, July 7, 1963; MD Texas Tech University School of Medicine, Lubbock, TX, 1988; surgery residency, same, 1988-93; elected by Central Medical Society.

**CHANDLER, NANCY D.,** Greenville. Born West Virginia, June 28, 1958; MD Louisiana State University School of Medicine, New Orleans, LA, 1984; one year transitional internship, LSU Medical Center; general surgery residency, Univ. Florida Medical Center, Jacksonville, FL, 1985-86; diagnostic radiology residency, LSU Medical Center, 1987-91; pediatric radiology fellowship, Los Angeles Childrens Hospital, Los Angeles, LA, 1991-92; elected by Delta Medical Society.

**CROSBY, SAMUEL N.,** Hattiesburg. Born Laurel, MS, Dec. 3, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1983; family medicine residency, Jackson-Madison County Gen. Hosp., Univ. of Tenn, Nashville, TN, 1983-86; elected by South MS Medical Society.

**CROSSEN, KARL J.,** Tupelo. Born Royal Oak, MI, Dec. 24, 1955; MD University of South Alabama School of Medicine, Mobile, AL, 1981; internal medicine residency, Washington University Medical Center, St. Louis, MO, 1981-84; cardiovascular diseases fellowship, same, 1984-87; elected by Northeast MS Medical Society.

**CURRY, GEORGE A., II,** Hattiesburg. Born Fairmont, WV, April 20, 1946; MD West Virginia

School of Medicine, Morgantown, WV, 1972; internal medicine internship, one year, Northwestern Memo. Hosp., Chicago, IL; neurology residency, University of Arizona Medical Center, Tucson, AR, 1973-76; neuro-ophthalmology fellowship, Univ. School of Medicine Medical Center, Los Angeles, 1976-77; neuro-radiology fellowship, same, 1977-78; elected by South MS Medical Society.

**DeROWEN, LENNIS J.,** McComb; Born Bay Springs, MS, June 8, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1992; emergency medicine residency, same, 1993-96; elected by South Central Medical Society.

**DeSANTIS, ROBERT A.,** Laurel. Born Ft. Belvoir, VA, July 22, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; ob/gyn residency, Tripler Army Medical Center, Honolulu, HI, 1991-95; elected by South MS Medical Society.

**DANIELSON, SHIRLEY S.,** Jackson. Born Mississippi, Aug. 8, 1958; MD Howard University College of Medicine, Washington, DC, 1984; internal medicine residency, Harlem Hospital, New York, NY, 1984-87; gastroenterology residency, same, 1988-90; elected by Central Medical Society.

**EVANS, HARRIS B.,** Gulfport. Born Jackson, MS, Aug. 28, 1949; MD Tulane University School of Medicine, New Orleans, LA, 1991; internal medicine residency,

University of Rochester, Strong Memo. Hosp., Rochester, NY, 1992-94; gastroenterology residency, Tulane Univ. Medical Center, New Orleans, LA, 1995-96; elected by Coast Counties Medical Society.

**FAJARDO, EMMANUEL A.**, Shubuta. Born Philippines, Oct. 29, 1967; MD FEU-NRMF, Philippines, 1992; internal medicine residency, Meharry Medical College Affiliated Hospitals, Nashville, TN, 1994-97; elected by East MS Medical Society.

**FERNANDEZ, JOSE P., JR.**, Meridian. Born Philippines, August 5, 1965; MD, Univ. of Philippines College of Medicine, Manila, Philippines, 1992; internal medicine residency, Long Island College Hospital, Brooklyn, NY, 1993-94; neurophysiology, LSU Medical Center, New Orleans, LA, 1997-98; elected by East MS Medical Society.

**FORKS, THOMAS PAUL**, Jackson. Born Great Lakes, IL, April 15, 1952; DO University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1988; family medicine residency, University Medical Center, Jackson, MS, 1989-91; elected by Central Medical Society.

**GALAN, ANTHONY R.**, Laurel. Born Puerto Rico, October 22, 1964; MD U.N.P.H.U, Puerto Rico 1989; interned one year, internal medicine, Allegheny Univ. Hospitals; Philadelphia, PA, gastroenterology residency, same, 1995-98; elected by South MS Medical Society.

**GREEN, JAMES REED, JR.**, Meridian. Born Jackson, MS, Feb.

6, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; orthopaedic surgery residency, University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1994-98; elected by East MS Medical Society.

**GRIFFITH, PATRICIA L.**, Clarksdale. Born Denver, CO, Sept. 24, 1960; MD Loyola Stritch School of Medicine, Maywood, IL, 1992; general surgery residency and orthopaedic surgery residency, same, 1992-97; elected by Clarksdale & Six Counties Medical Society.

**GULANIKAR, AVINASH C.**, Jackson. Born India, Oct. 29, 1959; MD G. S. Medical College, Bombay, India, 1983; interned and urology residency, Dalhousie University Medical Center, Halifax, Canada 1989-94; elected by Central Medical Society.

**GUNTER, KELLY P.**, Hattiesburg. Born Nashville, TN, Aug. 24, 1956; MD Meharry Medical College, Nashville, TN, 1988; radiology residency, Baptist Memorial Hospital, Memphis, TN, 1989-93; fellowship, diagnostic radiology, Vanderbilt Univ. Medical Center, Nashville, TN, 1993-94; elected by South MS Medical Society.

**HAMNER, DABNEY J.**, Jackson. Born Clarksdale, MS, March 25, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1988; ob-gyn residency, Tulane Medical Center, New Orleans, LA, 1988-92; elected by Central Medical Society.

**HEATH, GINA E.**, Jackson. Born Austin, TX, May 23, 1965; MD

University of Mississippi School of Medicine, Jackson, MS, 1992; surgery residency, Texas Tech Medical Center, Lubbock, TX, 1992-97; elected by Central Medical Society.

**HEINS, ANTON A.**, Tupelo. Born Teaneck, NJ, Jan. 9, 1946; MD University of Medicine & Dentistry of New Jersey-New Jersey Medical School, Newark, NJ, 1977; internal medicine residency, Same, 1977-80; elected by Northeast MS Medical Society.

**HUGHES, KAREN H.**, Jackson. Born Jackson, MS, Aug. 4, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; Pathology residency, same, 1993-98; elected by Central Medical Society.

**JACKSON, VERONICA Y.**, Meridian. Born Dekalb, MS, Jan. 28, 1968; MD University of Tennessee School of Medicine, Memphis, TN, 1994; interned and internal medicine residency, Methodist Hospital Center, Memphis, TN, 1994-98; elected by East MS Medical Society.

**JENNINGS, JOHN C.**, Brandon. Born Cleveland, Dec. 19, 1958; MD University of Mississippi School of Medicine, Jackson, MS, 1985; family practice residency, University of South Alabama Medical Center, Mobile, AL, 1985-88; elected by Central Medical Society.

**JOHNSON, JEFFREY NEAL**, Columbia, MS, Born Memphis, TN, Oct. 22, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, University of Tennessee Medical Center, Mem-

phis, TN, 1994-97; elected by South MS Medical Society.

**JONES, CONIGLIARO**, Crystal Springs, MS, July 6, 1967; MD Meharry Medical School, Nashville, TN, 1994; family practice residency, Henry Ford Medical Center, Detroit, MI, 1995-98; elected by South MS Medical Society.

**JORDAN, RENIE A.**, Tylertown; Born Africa, Aug 27, 1960; MD Byelorussia Medical Institute, Minsk, Soviet Republic, 1987; internal medicine residency, Howard University Hospital, Washington, DC, 1992-95; elected by South Central Medical Society..

**KIEHN, ROBERT K.**, Meridian. Born Oklahoma City, OK, July 29, 1943; DO Oklahoma College of Osteopathic Medicine, Oklahoma City, OK, 1979; interned, one year, Hillcrest Hospital, Oklahoma, OK; elected by East MS Medical Society.

**KONTOR, ANNAMARIA**, Yazoo City. Born TG-Mures, RO, April 24, 1967; MD Semmelweis University, Budapest, Hungary, 1993; pediatric residency, Henry Ford Hospital, Detroit, MI, 1995-98; elected by Delta Medical Society.

**MAIDAN, LUCIAN M.**, Meridian. Born Romania, Nov. 4, 1966; MD Carol Davila University of Medicine, Bucharest, Romania, 1992; neurology residency, University of California-Davis Medical Center, Sacramento, CA, 1995-98; elected by East MS Medical Society.

**MALLETT, JOHN H.**, Biloxi. Born Biloxi, MS, July 16, 1958;

MD University of Mississippi School of Medicine, Jackson, MS, 1985; ob-gyn residency, Richland Memorial Hospital, Columbia, SC, 1985-89; elected by Coast Counties Medical Society.

**MUNN, BARRY G.**, Jackson. Born Pennsylvania, Oct. 22, 1966; MD Tulane University School of Medicine, New Orleans, LA, 1992; general surgery internship, same, 1992-93; orthopaedic surgery residency, same, 1993-98; elected by Central Medical Society.

**NELSON-GARRETT, NINA P.**, Jackson. Born Jackson, MS, Sept. 13, 1963; MD University of Texas Medical School, Houston, TX, 1989; interned and internal medicine residency, Emory University Medical Center, Atlanta, GA, 1989-92; fellowship, gastroenterology , same, 1993-95; elected by Central Medical Society.

**OLUTADE, I. JOYCE**, Jackson. Born Nigeria, March 9, 1959; MD University of Ibadan College of Medicine, Nigeria, 1981; ophthalmology residency, same, 1983-87; transitional medicine, Emory Medical Center, Atlanta, GA, 1993-94; family practice residency, Morehouse Medical Center, Atlanta, GA, 1994-96; fellowship, one year, faculty development, same, 1996-97; elected by Central Medical Socioity.

**PARISI, FRANK**, Stennis Space Center. Born New Jersey, May 27, 1935; MD Georgetown School of Medicine, Washington, DC, 1962; pediatric residency, 1963-67, St. Michael Hospital, Newark, NJ; elected by Coast Counties Medical Society.

**PASHA, RIZWAN**, Meridian.

Born Pakistan, Sept. 22, 1966; MD Pakistan, 1991; interned and internal medicine residency, State University of New York Health Science Center, Brooklyn, NY, 1992-95; elected by East MS Medical Society.

**PAZ, JOSE E.**, Philadelphia. Born Lima, Peru, April 17, 1964; MD San Marcos University Medical School, Lima, Peru, 1992; internal medicine residency, University of Texas Medical Branch, Galveston, TX, 1994-97; elected by East MS Medical Society.

**POMPHREY, MARTIN M.**, Starkville. Born St Louis, MO, Feb. 2, 1943; MD St Louis University Medical School, St. Louis, MO, 1969; surgery internship, same, 1969-70; orthopaedic surgery, US Public Health Services Hospital, Staten Island, NY 1973-77; sports medicine fellowship, University of Alabama Medical Center, Birmingham, AL, 1990; elected by Prairie Medical Society.

**PRINGLE, DONALD F.**, Meridian. Born Ontario Canada, Nov. 2, 1936; MD Queen's University Medical School, Kingston Ontario Canada, 1963; interned Montreal Gen Hosp., Quebec and Charlotte Memorial Hospital, Charlotte, NC ; 2 year rotation in general practice, same, 1963-65; elected by East MS Medical Society.

**PURVIS, JAMES K.**, Jackson. Born Grosse Pointe, MI, July 25, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1991; pediatric residency, University of MS Medical Center, Jackson, MS, 1991-94; elected by Central Medical Society.

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**ULMER, J EDWARD**, Meridian. Born May 19, 1956; MD University of Mississippi School of Medicine, Jackson, MS, 1982; family

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**VANNORMAN, K MICHELLE**, Jackson. Born McComb, MS, March 18, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1995; pediatric residency, University of Tennessee Medical Center, Memphis, TN, 1995-98; elected by Central Medical Society.

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bama Medical Center, Birmingham, Al; emergency medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by South Central Medical Society.

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#### DEATHS:

**BELL, WARREN N.**, Jackson. Born Winnipeg, Canada, May 8, 1921; MD University of Manitoba Medical School, Manitoba, Canada, 1944; one year internship, Vancouver General Hospital, Vancouver, Canada; pathology residency, McGill Univ., Canada 1948-49 and University of Pennsylvania, 1949-50; hematology residency, same, 1950-52; fellowship in Hematology, University of Cambridge, England, 1953-54; died Jan. 22, 1999, age 77.

**BYARS, WILTON V., II**, Greenville. Born Oxford, MS, Oct. 30, 1938; MD University of Mississippi Medical School, Jackson, MS, 1966; interned one year, same; ob-gyn residency, same, 1967-70. Died Jan 23, 1999, age 60.

**CARPENTER, DON E.**, Jackson. Born Hattiesburg, MS, Oct. 15, 1954; MD University of Mississippi School of Medicine, Jackson, MS, 1979; interned & neurology residency, University Medical Center, Jackson, MS, 1979-84; died February 22, 1999, age 44.

**ELLIS, MARSHALL S.**, Clarksdale. Born Holly Springs, MS, Jan. 16, 1926; MD University of Tennessee College of Medicine, Memphis, TN, 1965; interned one year, Methodist Hospital, Memphis, TN; died Jan. 12, 1999, age 73.

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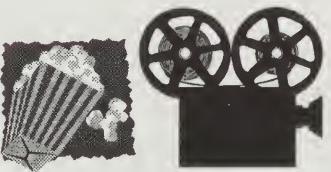


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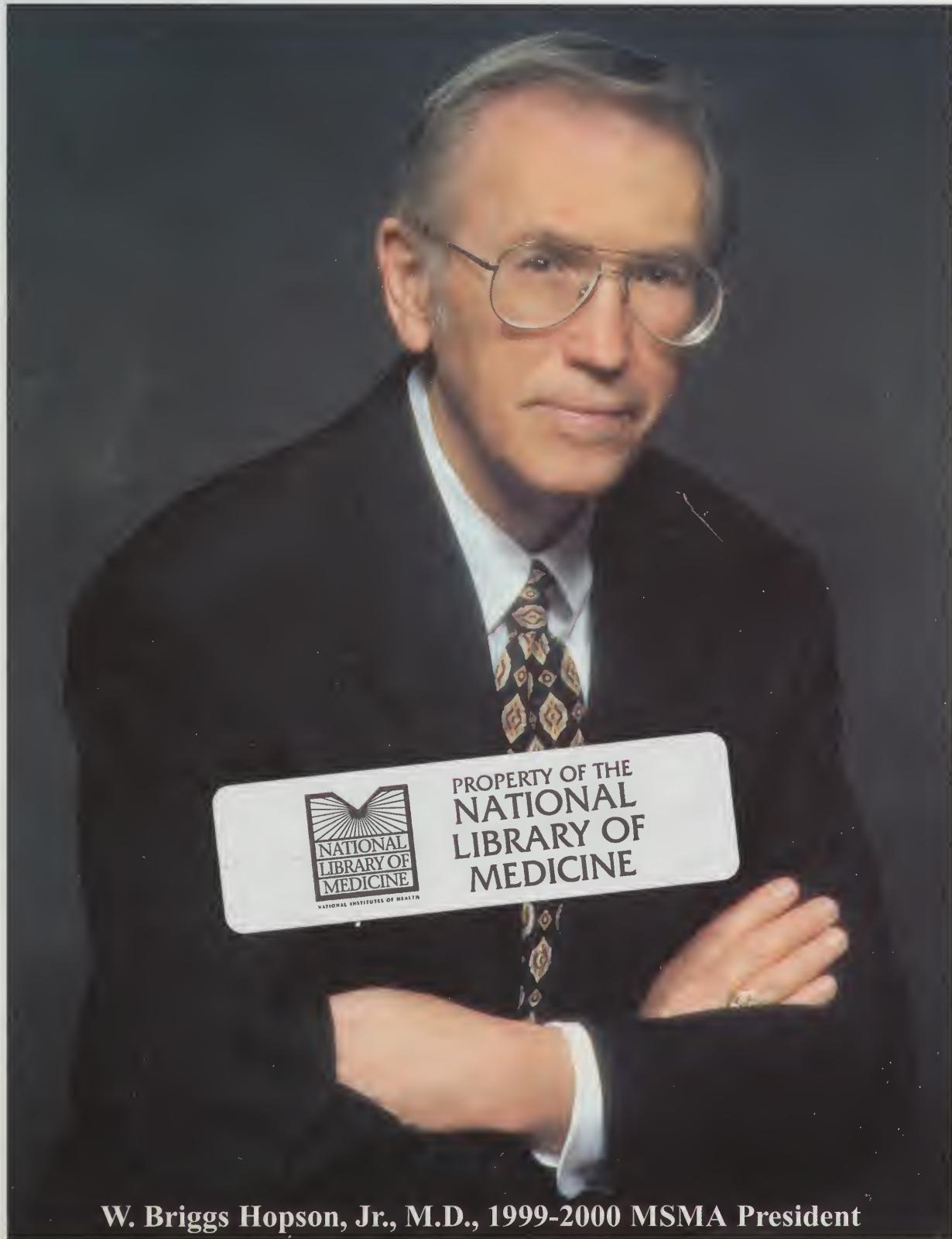
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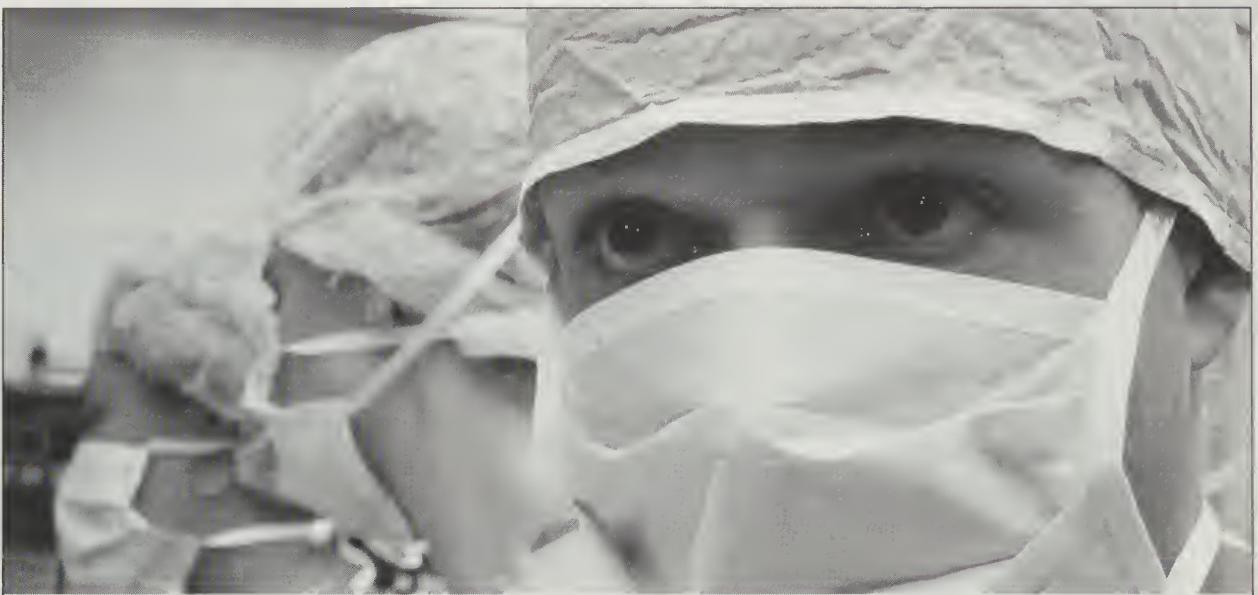
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*The following abstracts presented at the Mississippi American College of Physicians Associates' Annual Meeting represent the first of a three-part series to be published in subsequent issues of the JOURNAL MSMA.*

—ED.

## Methemoglobinemia in a Seven-Year-Old Given Benzocaine After A Tonsiladenoidectomy

N. Karol Anderson, M.D. (Associate),  
Department of Medicine and Pediatrics,  
University of Mississippi Medical Center

Methemoglobinemia (MHB) results from chemical exposures oxidizing ferrous hemoglobin (Fe+2) to its ferric (Fe+3) state. A 7-year-old girl was transferred to University Hospital after developing pallor, lethargy, and pulse oximetry O<sub>2</sub> saturation of 75-78%. The patient had undergone an uneventful tonsil adenoidectomy at 8:00 am and done well until 14:00 when O<sub>2</sub> sats dropped despite increased FiO<sub>2</sub>. ABG on FiO<sub>2</sub> 1.0 was 7.353/608/35 with measured O<sub>2</sub> sats 100% and pulse oximetry sats 86%. She experienced a seizure, was intubated, and transferred by air ambulance. Upon arrival (18:20), the patient was unresponsive except to painful stimuli with 3 mm equal and sluggish pupils, cyanotic lips and extremities, and dark blue mucous membranes. O<sub>2</sub> sats were 60% on 100% O<sub>2</sub> and ABG was 7.445/503/21 (FiO<sub>2</sub> 1.0). Blood was noted to be dark brown. A clinical diagnosis of MHb was made and 2 mg/kg of methylene blue was initiated at 18:55. Her minimum O<sub>2</sub> sat was 26%. She received one additional dose of 1 mg/kg of methylene blue.

Serial ABG's and Mhb levels were:

	HD#1				
	18:30	FiO <sub>2</sub>	1.0	7.445/503/20.9/14.5	MHb 68.2
	19:08	FiO <sub>2</sub>	1.0	7.465/428/20.6/14.9	MHb 47.3
	00:45	FiO <sub>2</sub>	1.0	7.488/493/19.1/14.6	MHb >10
	07:00	FiO <sub>2</sub>	1.7	7.438/228/25.3/17.3	MHb 5.5
	14:25	FiO <sub>2</sub>	0.4	7.402/154/33.0/20.8	MHb <5

Glucose-6-Phosphate-Dehydrogenase (G-6-PD) level was normal. The patient was extubated on hospital day #3, transferred to the floor on hospital day #4, and discharged on hospital day #5. Review of her outside records showed that the patient received 1 g ceftriaxone, and 5cc of 20% benzocaine preoperatively, and 8 mg dexamethasone postoperatively.

Many oxidizing agents can result in MHb including nitrates, nitrites, paints, phenacetin, sulfonamides, Pyridium, lidocaine, and benzocaine. Cyanosis occurs with MHb levels > 15%. Pts. become symptomatic at levels of approximately 30%, developing fatigue, head-

ache, dizziness, tachycardia, and weakness. At levels of > 55%, dyspnea, bradycardia, hypoxia, acidosis, seizures, coma, and arrhythmias occur. Death usually occurs with levels > 70%. Hemolytic anemia may lead to hyperkalemia and renal failure 1-3 days after exposure. Cyanosis in conjunction with a normal PaO<sub>2</sub> and decreased O<sub>2</sub> sat (measured by oximeter), with "chocolate brown" blood suggests the diagnosis. Methylene blue, which decreases the T<sub>1/2</sub> of MHb from 15-20 hours to 40-90 minutes, is indicated for MHb levels > 30 g/l or the presence of MHb coupled with hypoxia. Methylene blue is contraindicated in G-6-PD deficiency. Administration of 100% O<sub>2</sub> and packed red blood cell transfusions may be indicated in G-6-PD deficient pts.

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## Neurocysticercosis with Focal Neurological Deficits in a Nicaraguan Immigrant

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*Taenia solium* (pork tapeworm) is the most common parasitic infection of the central nervous system worldwide, with the majority of cases found in developing countries and associated with the ingestion of undercooked pork. The ease of international travel, rising immigration from developing countries and improved diagnostic techniques have led to the recognition of an increasing prevalence of neurocysticercosis in the United States, predominantly in the southwestern regions. Neurocysticercosis is not a reportable condition and is more rarely seen in the southeast, with no incidental reports in Mississippi in 15 years. The most common presentations are seizures (60%), altered mental status (15%), headaches and papilledema (10%), and focal deficits (10%).

A 37 year old female Nicaraguan immigrant, resident in the southwestern U.S. for the past 12 years, relocated to MS 3 months prior to presentation. She

developed an acute onset of right-sided paresthesia and weakness without seizure activity or headache. On examination she demonstrated a marked loss in motor strength in right upper and lower extremities with decreased sensation to light touch. Her initial workup included CT head and MRI brain imaging which revealed multiple homogenous contrasting and non-contrasting cysts within the parenchyma consistent with neurocysticercosis. A single large lesion with associated edema was seen; Dilantin was initiated prophylactically. Oral steroids were provided to reduce local inflammation and as prophylaxis for anticipated rapid cyst death following albendazole therapy. Her symptoms improved on steroids, and monitoring during the first 72 hours of albendazole therapy was without complication. This case represents a less common presentation of a locally rare disease.

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## Hyperthyroidism Resulting From A TSH Secreting Pituitary Adenoma

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Hyperthyroidism denotes the presence of elevated levels of circulating thyroid hormones. The clinical manifestations vary among different individuals, but includes nervousness, heat intolerance, restlessness, palpitations, and change in weight. An elevated free T<sub>4</sub> makes the diagnosis but, if the TSH is measurable, as in the patient presented below, causes of central hyperthyroidism must be evaluated.

Our patient is a 34 yo white female who presented to her family doctor in 1994 with complaints of nervousness and frequent heart palpitations. She received the diagnosis of hyperthyroidism (lab was unavailable) and was started on methimazole and propranolol with improvement in her symptoms. She did well until 1997 when she noticed a painless enlargement in her neck. She presented for evaluation. Her only complaint was of the neck swelling. She denied weight changes, heat/cold intolerance, nervousness, fatigue, and frequent bowel

movements. She did report occasional heart palpitations. Also of note she had been given the diagnosis of Bipolar Disorder and started on Lithium. Physical exam was significant for a normal pulse, bilateral lid retraction with lid lag, a diffuse goiter and hyperreflexia. Lab: FT4 4.6 ng/dL (0.7-1.9); TSH 1.69 mIU/ml (0.46-4.98). Growth hormone, prolactin, follicle stimulating hormone, luteinizing hormone was all normal. The patient then underwent a TRH stimulation test, which revealed a normal response of TSH. Alpha subunit was found to be 1.3 ng/ml (<1.0) with a molar ratio of 6.6 (alpha subunit/TSH x 10). Thyroid Peroxidase antibody was negative. MRI of head revealed a 0.8 x 1.2 cm pituitary lesion. Formal visual field testing revealed a small supertemporal visual field defect in the left eye. Patient was sent to surgery for transphenoidal resection of her TSH secreting pituitary adenoma.

Central hyperthyroidism must be considered in any patient with an elevated FT4 and an inappropriately normal or elevated TSH. The causes are a TSH secreting pituitary adenoma or resistance to thyroid hormone. Family history, dynamic tests (TRH stimulation, T3 suppression), measurement of the alpha subunit and calculation of the molar ratio, and radiographic imaging help to differentiate these entities. TSH secreting pituitary adenomas are rare and account for 0.1-1% of all pituitary adenomas. Once a TSH adenoma has been diagnosed surgery is the mainstay of treatment. These tumors are often large and invasive. Radiation therapy is sometimes used if total removal of the tumor is impossible. Cure rates for surgery +/- radiation is only about 33% with cure being defined as complete removal of tumor mass and normalization of circulating thyroid hormone levels. Approximately 33% of patients are improved (normalization of thyroid hormone level without complete removal of tumor mass). Approximately one third of patients remain thyrotoxic and require medical therapy. The SRIH analog octreotide has been shown to be effective in reducing TSH and the alpha subunit with restoration of the euthyroid state in the majority of patients (72-95%) who have failed conventional treatment.

## Facial Nerve Paralysis from Intracranial Blastomycoma

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Blastomyces dermatitidis is a dimorphic fungus that causes a chronic infection characterized by suppurating and granulomatous lesions in skin, bone, lung, genitourinary organs, and central nervous system. Disseminated blastomycosis involves the central nervous system in 6 to 10% of the cases, and is reported to be as high as 33% in systemic disease cases at autopsy. The usual port of entry is lung, though occasional infection through the skin has occurred. Abscess or granuloma formation behaves like a mass lesion and is occasionally the presenting clinical picture. In a review of the literature, we found no cases reporting a cranial nerve paralysis from intracranial blastomycoma. I am reporting a case of acute onset facial nerve paralysis that was biopsy-proven blastomycosis.

**Case Presentation:** A 49-year-old white male and long-time farmer who had complaints of right ear fullness for approximately one month. He was seen by his local physician and treated for an "ear infection". Six days prior to presentation, he awoke with the inability to close his right eye, and noticed some drooling from the right corner of his mouth. He had also observed some slurred speech at that time. A CT head at the outside hospital revealed a mass in the temporal fossa, as well as opacification of the mastoid air cells with fluid present. He had also reported diminished hearing in the right ear over the past month. He was referred to UMC for an ENT evaluation. Additional work-up revealed mixed hearing loss in the right ear by audiogram. MRI of the brain with and without contrast demonstrated findings consistent with inflammatory disease, likely chronic, involving the mastoid air cells on the right with involvement of the petrous apex and thickening of the dura surrounding the inferior temporal lobe. CT of the orbit and sella showed right mastoiditis and otitis with destruction of petrous apex and carotid canal dehiscence. The patient was scheduled for middle ear exploration and biopsy. Surgi-

cal findings revealed a large exophytic bulky mass filling the entire right middle ear cavity with involvement of the tympanic membrane. The ossicles were not visualized. Pathological results were indicative of a blastomycoma. Initial follow-up after two weeks of oral itraconazole 100 mg twice a day showed improvement of the patient's ability to close his right eye, as well as some return of his hearing in the right ear.

**Discussion:** Blastomycosis is endemic to the Ohio and Mississippi River valleys, and commonly affects adult males with outdoor occupations. Intracranial blastomycosis without previous systemic manifestations is rare. In retrospect analysis, a temporal relationship can usually be defined. Pulmonary complications are sometimes self-limiting, and often not associated with further manifestations of disseminated infection. Among the systemic mycoses, blastomycosis most nearly mimics the CNS involvement seen with tuberculosis and lung cancer. The literature review supports the idea that CNS involvement by *Blastomyces dermatitidis* is nearly always the result of hematogenous spread from a pulmonary etiology, occurs as a result of infection in contiguous structures, or underlies osteomyelitis. Patients without a history of an acute respiratory illness probably represent the occurrence of endogenous reactivation after asymptomatic infection.

vascular disease.

A 63 year old male veteran with a long history of benzodiazepine treatment for anxiety and panic attacks presented to the admissions office complaining of nausea, dizziness, and "passing out". He was noted while in the admissions office to experience nausea with a small amount of emesis followed by a brief period of asystole. This resolved spontaneously at initiation of ACLS protocol. The patient reported a long history of frequently losing consciousness without obvious cause or precipitating events. He had been repeatedly evaluated for ischemic cardiac disease, including three exercise tolerance tests and a cardiac catheterization. He had two prior admissions for syncope evaluation, during which a CT scan of his head, EEG, carotid dopplers, and ventilation perfusion scan were performed. During this admission at the VA, he was noted to experience profound bradycardia with symptoms when pressure was applied to his carotid sinus. As this phenomenon was not reliably reproducible, he was scheduled for head upright tilt table testing. During that evaluation, he experienced prolonged asystole; a dual chamber demand pacemaker was then placed. Over the subsequent six months, he has experienced no syncope and his anxiety is much improved.

This case illustrates the utility of head upright tilt table testing in selected patients with unexplained syncope. This test can unmask a predisposition to hypotension and bradycardia while in a controlled environment. Tilt table testing is an underutilized method of evaluating syncope, a diagnostic dilemma which can lead to significant morbidity and even mortality, particularly among the ever increasing elderly population.

## An Unusual Case of Carotid Hypersensitivity

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Syncope, with multiple etiologies and varied mechanisms, may present a significant diagnostic challenge to the primary care physician. Unexplained losses of consciousness may be seen in up to 30% of the general population and account for approximately 1% of hospital admissions. Cardiovascular causes of syncope carry a five year mortality rate as high as 50%; neurally mediated syncope has a much more favorable prognosis. In many cases the distinction may be unclear, as some "non-cardiovascular" causes of syncope are related to cardio-

## Bone Metastasis Revealing Hepatocellular Carcinoma

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Hepatocellular Carcinoma is a highly malignant Neoplasm, relatively uncommon in the US (<2.5% of all malignant tumors). Risk factors include cirrhosis,

hepatitis B and C, hemochromatosis, alpha 1 antitrypsin deficiency and exposure to aflatoxin. Extrahepatic metastasis is found in 64% of patients. Most common sites are regional lymph nodes, kidneys, bone marrow and adrenals. Bone metastasis found in less than 5% of patients, but initial presentation as bone metastasis is rare.

We herein present a case of 64 years old male previously healthy, no history of alcohol use or hepatitis, presented with lower back pain, radiculopathy, numbness and weakness of the right leg. Physical examination revealed normal liver span, no ascites and no evidence of chronic liver disease. Found to have a large lytic lesion involving L5-S1 by MRI. FNA was not conclusive (poorly differentiate malignant cells, and Plasmacytoma could not be excluded). Multiple myeloma was excluded by bone marrow and protein electrophoresis. A CT guided punch biopsy of the lesion revealed large cells with fat globules consistent with liver or renal cell carcinoma. On further workup a 4X 4 cm dense lesion found in the liver, and FNA confirmed the diagnosis of hepatocellular carcinoma. Liver function test were normal as well as alpha-feto-protein. Hepatitis screen was negative.

Osteolytic lesions as metastasis from hepatocellular carcinoma most commonly affect spine, ribs and skull. Alpha fetoprotein immunoperoxidase staining of biopsy may help in the identification of liver cells in cases of silent primary tumors. Although rare, occult hepatocellular carcinoma may present as lytic bone lesions.

soning culminating in multi-system failure.

GG is a 47 year old Caucasian male who presented to his local ER via ambulance three days after attempting suicide by injecting himself intravenously and subcutaneously with copper sulfate from his art supplies. On day 1, he developed nausea, vomiting, diarrhea, hematemesis, and hematuria within fifteen minutes of injection. The following day he became anuric and was having diffuse abdominal pain and myalgias. By day three, when GG presented to the hospital, he had become jaundiced. On arrival, GG was hypotensive and having melena and hematemesis. His hemoglobin was 5 g/dl, hematocrit 9.4%, platelet count 94,000/cmm, and CPK 2528 u/L. GG received 3u PRBC and 3 units FFP. He was also given penicillamine 40 mg/kg and BAL 5 mg/kg IM on two occasions prior to transfer to UMMC.

On arrival to UMMC, pertinent physical exam findings included jaundice, diffusely tender abdomen without peritoneal signs or hepatosplenomegaly, and occult blood positive stool. GG was prepared for hemodialysis on arrival secondary to acute renal failure. He received 4 units PRBC during the initial hemodialysis. EDTA was infused prior to the first two dialyses. There was no marked change in the blood copper levels after dialysis. Copper was detected in the dialysate with values of 25 mcg/L and 20 mcg/L in the beginning and the end of dialysis, respectively. EDTA was discontinued. On day three, serum copper levels was unchanged comparing pre and post-dialysis levels. By this time, GG was clinically and subjectively better. Before discharge, GG's urine output had increased to 800 cc over the previous 24-hour period. His creatinine peaked at 14 mg% and was 12.8 at discharge. Six weeks after the injection of copper sulfate, his creatinine was 1.7, and GG was doing well. The GI manifestations which GG experienced are typical and previously attributed to direct contact effect of the poison on the GI mucosa. The fact that GG experienced the same symptoms following parenteral route suggests that the pathogenesis may not be due to direct toxicity.

Copper sulfate poisoning, although rare, results in high mortality compared to other poisonings. Our case is the only known to us involving parenteral toxicity. The manifestations are the same, including metallic taste, nausea, vomiting, epigastric pain, diarrhea, hemoglobinuria, hematuria, renal failure, liver failure, hypotension, melena, and coma, but at a much lower dose. Most reports of copper toxicity occur at doses of at least 1 g. GG used approximately 50 mg. Therapy is supportive. Serum copper levels and severity of symptoms do not appear to correlate, probably due to the rapid influx of copper into

## Parenteral Copper Sulfate Poisoning Causing Acute Renal Failure

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Copper sulfate toxicity is a rare event in the United States but is commonly used as a form of suicide in India. A literature search revealed few cases of enteral copper sulfate toxicity but no cases of parenteral poisoning. This case report describes an intravenous copper sulfate poi-

red blood cells. It is recommended that whole blood levels, rather than serum levels, be measured. Chelation therapy is often used and penicillamine and dimercaprol are recommended. Ours is the second reported case which used EDTA with a successful outcome. There is still however, insufficient evidence to suggest a definite role for EDTA in the treatment of copper toxicity. This case demonstrates greater toxicity at lower doses by intravenous and subcutaneous injection compared to enteral toxicity of copper. With treatment, however, the sequelae were reversible.

## Empyema at Keesler Medical Center

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**Purpose and Methods:** We conducted a retrospective review of empyema at Keesler Medical Center between August, 1992 and September, 1997 to determine clinical features, microbiology and treatment. Inpatient records from the study period were searched for empyema or related diagnoses. These records were reviewed for demographic, clinical and laboratory data.

**Results:** 16 records were identified in our initial search. 13 patients were male, 3 female. Mean age was 48 (range: 3 to 86 years). Most patients presented with complaints of fever (9), shortness of breath (3) or pleuritic chest pain. The majority of patients had effusions which were loculated (15), and almost half were smokers (7). Five patients had underlying anatomic derangements, such as obstruction. Only 2 patients were treated with streptokinase and of those only one was successfully treated. One patient had rheumatoid arthritis as well. Out of this series only one patient died, with the vast majority recovering well (14). A surprising number (10) of patients were treated initially with chest tube placement or CT guided drainage initially with only 2 failures. Half of the patients required surgical intervention and decortication (8). The majority of chest tubes used were 32 to 36 French and stayed in an average of 14 days. One patient expired during treatment and another was left with a chronic effusion, after failure of chest tube drainage.

**Conclusions:** Empyema at Keesler Medical Center is most likely to occur in patients with underlying anatomic derangements and/or systemic illnesses. Prompt treatment with thoracostomy or thoracotomy led to a low rate of complications and only one death.

## Adult Respiratory Distress Syndrome (ARDS) Due to *Blastomyces dermatitidis* in a Young Immunocompetent Patient

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*Blastomyces dermatitidis* is a relatively common cause of fungal pulmonary infections in endemic areas but rarely progresses to ARDS. A previously healthy 19-year-old male presented with a four-week history of joint pains, shortness of breath, fevers, chills, and a productive cough. Other complaints included fatigue, night sweats, and a 20-pound weight loss over the preceding month. He was afebrile but in mild respiratory distress. His lungs were clear except for a few crackles in the left base. The right elbow and left ankle were tender and warm but without erythema or effusion. Chest radiograph revealed a pO<sub>2</sub> of 47, pCO<sub>2</sub> of 28, and pH of 7.486. He was initially treated with IV Bactrim and steroids for possible Pneumocystis pneumonia and broad-spectrum antibiotics. Initially the patient improved but on hospital day four his respiratory status worsened requiring mechanical ventilation. After being moved to Intensive Care, he underwent bronchoscopy with bronchoalveolar lavage which revealed budding yeast consistent with *Blastomyces dermatitidis*. Over the next several days, he became more difficult to ventilate and demonstrated worsening of his bilateral pulmonary infiltrates despite treatment with Amphotericin B. The patient expired on hospital day seven.

Few cases of ARDS associated with *Blastomyces dermatitidis* infection have been reported. We are able to

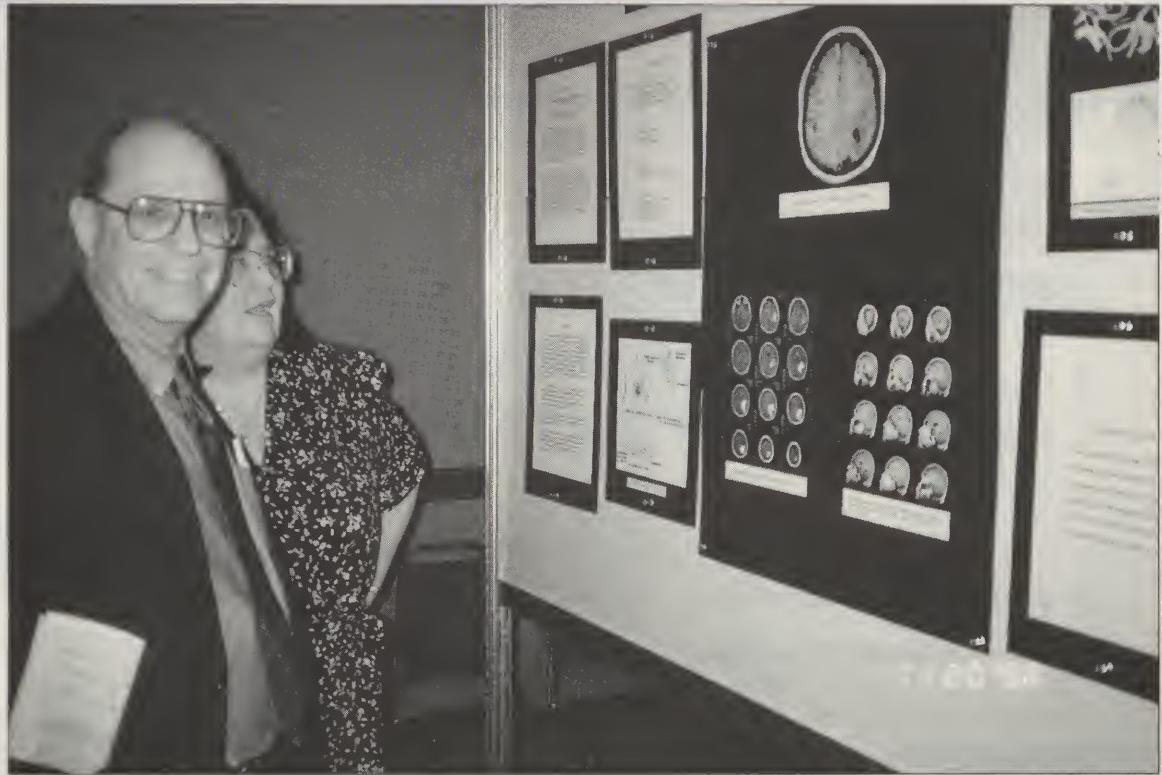


Fig 1.—Dr. Kent Kirchner, Chief of Medical Services at the Jackson Veteran's Affairs Medical Center, reviews Dr. Donna Kaye Cassell's poster on Neurocysticercosis.



Fig 2.—Dr. John Bower, Chief of Nephrology at the University of Mississippi Medical Center, enjoys the ACP-ASIM social with several of the ACP Associate participants: Dr. Kimberly Harkins, Dr. Karol Anderson, Bower, Dr. Gwen Oldenquist.

document only twenty-nine cases in the English literature. A review of cases suggests that Amphotericin B given in doses of one milligram per kilogram within forty-eight hours of presentation offers the best chance for survival. This unusual case is an important reminder that relatively common diseases may present with uncommon manifestations.



Fig 3.—Dr. Van Lackey, Governor of the Mississippi Chapter of the ACP-ASIM.

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# Thomas D. Isom, M.D.: Pioneer Physician, Confederate Surgeon, and Oxford's First White Settler

Harris D. Riley, Jr., M.D.  
Frank A. Riley, J.D.

**T**homas Dudley Isom was born in Maury County, Tennessee, 5 September 1816. He was the second child born of James and Mary Gale Isom who were natives of Virginia and pioneers of Middle Tennessee. His father was a farmer, and died in 1824; his mother lived until 1851. Dr. Isom received his early education mainly under Professor Samuel P. Black, a prominent educator of early days, at Pebble Hill Academy, in Rutherford County, Tennessee.<sup>1</sup>

In 1835, Isom traveled south with his inheritance—a horse, a saddle, and a bridle—to the part of Lafayette County known as the “Ridge.” He journeyed first to Tullahoma, Mississippi, then was sent by his uncle, John J. Craig, a partner in the trading post of Chisolm, Martin, and Craig in Pontotoc, Mississippi, with a supply of goods to set up trading with the Chickasaw Indians on the present site of Oxford. To conduct business, he built by hand a three-room log cabin out of the virgin forest. Thus, Isom Place was born and Thomas Dudley Isom became Oxford’s first white settler.<sup>2</sup>

Mississippi was admitted into the Union in 1817; Lafayette County was constituted in 1836. This county was one of ten organized out of the territory ceded to the state by the Chickasaw Nation. By 1837, Isom’s occupation as a trader had diminished, and under the treaty of Pontotoc Creek, most of the Chickasaws were relocated to what would become Oklahoma. From the start Isom had established friendships with many of the Chickasaws, notably Hoka, the Indian princess who deeded much of

Oxford to the company, Chisolm, Martin, and Craig, and Chief Toby Tubby. Intent that the Chickasaw names and deeds not be forgotten, Isom often reminisced about them, thus providing the present generation with those important Chickasaw tales which are a great part of Mississippi’s heritage. Years later, Thomas Isom would recall his feeling for the land-disposed Chickasaws. He called the Mississippi holdings “a fair and goodly land”.<sup>2</sup>

When the Indians were removed to Indian Territory, Isom returned to Tennessee and studied medicine under Dr. John S. Spindle for a year. In 1837-38, he took a course of lectures at Transylvania University. During the years of 1838 and 1839, he was enrolled at Jefferson Medical College, Philadelphia, Pennsylvania, from which he was graduated in 1839. He returned to Oxford to practice his profession, which would span sixty years.<sup>1</sup>

Isom’s three room log cabin became the first pharmacy along with the only medical practice in Lafayette County. In 1840-41, Thomas Dudley Isom met and married Miss Sarah McGehee of Abbeville, South Carolina. Miss McGehee had come to Lafayette County to visit her twin sister, Miss Mary McGehee, a future wife of Mr. James Barr of Pontotoc. Sarah McGehee had set out for Mississippi to visit her sister and there, in the home of Mr. Barr, Sarah McGehee met Thomas Isom. Later that year, Dr. Isom traveled to South Carolina to claim his bride and bring her home to

Isom Place, the name of his home in Oxford.<sup>2</sup>

Between 1840 and 1862, the original two story vernacular frame house was built. For years the business name, “Isom Place and Drug Store House,” could be seen inscribed on the kitchen windowsill box. A wide hall ran down the center the length of the house with large rooms on either side. One of these rooms, the dining room, was made large enough to not only accommodate a normal family (Sarah and Thomas had nine children), but also to accommodate meetings of the Board of Trustees of the University of Mississippi. It was at Dr. Isom’s dining room table that the University of Mississippi [Ole Miss] went from being a dream to a reality. The house was built by Indian and slave labor and sat in its 160 acres.<sup>2</sup> The house and property recently has been purchased by Ms. Sarah Barksdale and converted to a bed and breakfast facility called Barksdale-Isom House.<sup>2</sup>

By 1860 the Isoms had become firmly established in the township now known as Oxford. Dr. Isom, in fact, named the town after the great university in England, in hopes that this fledgling university would one day uphold the fine academic traditions of its namesake. Dr. Isom also participated widely in community and state affairs.<sup>2</sup>

When Abraham Lincoln won the presidential nomination of the anti-slavery Republican party and then prevailed in the 1860 election over a split Democratic party, Southern leaders, who had threatened to secede from the Union, made good on their threat. South Carolina was the first state to leave. Mississippi was second, adopting its Articles of Secession on January 9, 1861. They were drafted by L.Q.C. Lamar, a prominent Mississippian, a mathematics professor at the University and later a United States Supreme Court Justice. It was the first of many associations between the Oxford campus and the Confederate cause.<sup>3</sup>

Dr. Isom attended the State Secession Convention in 1860. He attempted earnestly to prevent Mississippi’s secession, but when he saw the inevitable, he signed the ordinance believing primarily in the unity of his people.<sup>3</sup>

News of secession was greeted with wild enthusiasm at the University of Mississippi and in Oxford. The flag of the United States had been replaced by the flag of the newly independent State of Mississippi, waving profusely from every window. A campus literary society approved a motion that “two abolition books in our library be burnt” and then voted to purchase a copy of the secession ordinance. One professor was dismissed for drafting a letter that appeared to express “Northern sentiments”.<sup>3</sup>

In anticipation of the coming hostilities, a military company of students had organized a few weeks before

secession became official. They were called the “University Greys,” and they fervently asked to be pressed into service even though their parents and families opposed the move.<sup>3</sup>

Hostilities between the North and South began 12 April 1861, after Ft. Sumter in Charleston, South Carolina was fired on. Two weeks later the University Greys became part of the Confederate Army, the excitement of war, overwhelming all concerns about their youth and inexperience. Many were later killed at Pickett’s charge at Gettysburg. But they had made an indelible imprint on the school with their youthful but fatal enthusiasm, serving as an inspiration to later generations of university men who battled on the athletic fields.<sup>3</sup>

A month after actual fighting began, all but five students had left the campus. “We are indeed the inhabitants of solitude,” Chancellor Barnard wrote a friend in Washington, D.C. “Our university has ceased to have a viable existence. Its halls are completely deserted, and its offices are without occupation.”<sup>3</sup>

The Board of Trustees hoped that they could keep the school open, but by Fall it was clear that the campus would have to shut down. The faculty had already recommended suspending operations, and by mid-October, only four students had applied for admission. It was unlikely very many more would be matriculating.<sup>3</sup>

The Board had been reluctant to close the school, fearing that an empty campus would be looted and damaged. But by November, the Trustees realized it was a risk they would have to take. Two faculty members were instructed to remain on campus to watch over the buildings. On 21 November 1861, Barnard made his last report to the Trustees. While criticized by some, in Oxford he had gained appreciation for his efforts on behalf of the University. In their final act before closing the school, the natives bestowed on the Chancellor an honorary doctor of divinity degree, a decent gesture befitting a man who would go to greater claim as head of Columbia University.<sup>3</sup>

Immediately after seceding from the Union on 9 January 1861, Mississippi forces began seizing United States property following this action. Dr. Isom volunteered as the surgeon for the 17th Mississippi Volunteer Regiment and accompanied the regiment to Virginia. Upon arrival he was placed in charge of the Mississippi hospital at Warrenton, Virginia.<sup>4</sup> On 25 June 1861, Private Robert A. Moore of the 17th Mississippi regiment now in Virginia wrote in his diary, “Surgeon Isum [Thomas D. Isom] of our reg. came up last night, he has the reputation of being a skillful surgeon”.<sup>5</sup>

Within six months of closing, the University's buildings were turned into hospitals. The care of the sick, wounded and dying only deepened the pain of the entire war for survivors, turning the campus into many shrines to the lost battles.<sup>3</sup>

The first Confederate sick and wounded were sent to Oxford in March 1862. Their number rapidly increased a month later after the battle of Shiloh, fought over two days in Southwest Tennessee near the Mississippi border. Casualties on both sides were heavy; the Confederacy lost more than 1,750 men with more than 8,000 wounded. The Union casualties were similar.<sup>3</sup>

"Every building on the campus was used to care for the sick, and every available space was crowded with pallets holding the wounded.\* There was barely a passage way for attendants to move between the sick and wounded soldiers. Oxford residents willingly offered their help, sending over mattresses, cots, and bedding to supplement the provisions the Confederate army was sending in from New Orleans and Vicksburg until the Union army cut off supply sources."<sup>3</sup>

The physicians made available to the make-shift hospital were forced to rely on the women of Oxford to act as nurses; each of them took turns carrying food from their home to the wards. Survivors remembered it as a period of "self-sacrifice and deprivation" willing accepted "for the cause was a common cause."<sup>3</sup>

Dr. Isom was recalled from Virginia and placed in charge of the hospital at the University of Mississippi. The author of an article on the University War Hospital in Oxford had this to say about Dr. Isom: "...Dr. T.D. Isom, well-known and beloved by all Oxford people, a man whose noble character and life of Christ-like service to his fellow men needs no encomium, was appointed post surgeon. He was assisted in his work by many faithful men, among them Dr. Gillespie of Grenada, and Drs. Chandler, Phipps, Stover, Brown, King, and Buffington of Oxford, besides others whose names have not been ascertained."<sup>6</sup>

Isom treated both Union and Confederate. Because of Dr. Isom's kindness to the wounded Union soldiers, it is said General Grant personally ordered two Union officers to be stationed at Isom Place to prevent its destruction.<sup>2</sup>

\* One building was used as a morgue and quickly acquired the title of the "Dead House". After the war, it served as the meeting place for the first fraternity at the University of Mississippi, Delta Kappa Epsilon. *Oxford Eagle*, February 6, 1958.

In November the hospital had to be hastily disbanded when word came that the U.S. Army under General Ulysses S. Grant was approaching Oxford. The wounded were rushed to outposts south of the campus.<sup>3</sup> Before Grant arrived, however, a group of Kansas soldiers invaded the town, destroying many stores before they rode rapidly onto the campus. They burst into the building used as headquarters and destroyed much of the medical equipment before their commanding officers arrived and ordered them back to camp.<sup>3</sup>

Grant came into Oxford early in December 1862 intent upon burning the buildings because they had been used for "war purposes." But he abandoned that plan when two of the professors still on campus persuaded the General that using the building as a hospital was not really a "war purpose." Besides, the Union Army might have similar use for the buildings. There was also wide speculation that "Damn Yankee" Barnard, the recently departed Chancellor, tried to help, appealing to Grant to spare the school.<sup>3</sup> The General subsequently honored another request to put a guard around the university buildings, ensuring their protection. Oxford itself was not so lucky. Eighteen months later Federal forces burned the town, including the court house, and all the local public records in it.<sup>3</sup>

Grant stayed at the University only three weeks. He was forced to return to Memphis after Confederate troops outflanked him to the west and severed communications with other Union forces.<sup>3</sup>

Shortly after Grant departed, the campus reverted to a hospital again, but the building housing the wounded was in terrible shape-its walls defaced, its floor crumbling from neglect and its furnishings barely usable-the "poorest of cots and covers; one dilapidated chair for each occupant, and a few tables and wash stands scattered about, all made my heart ache, as I remember them yet," recalled one Oxford woman who volunteered as a nurse.<sup>3</sup>

By the time General Robert E. Lee surrendered to Grant on 9 April, 1865, roughly 1,850 patients had been cared for at the university. More than 700 of them died.<sup>7</sup> They were buried in the cemetery on campus but their grave markers were later destroyed when workmen carelessly failed to protect them during a clean-up of the area. The mounds covering their bodies were leveled and grass was planted over the entire spot, obscuring the fact that it was the final resting place for the dead soldiers.<sup>3</sup>

Several years later after the war, a monument to their memory was put up by the United Daughters of the Confederacy. As Cohodas stated, "Later events made clear the UDC need not have worried that the Confederate dead would be forgotten. The debate would be over how

they were remembered and for what.”<sup>3</sup>

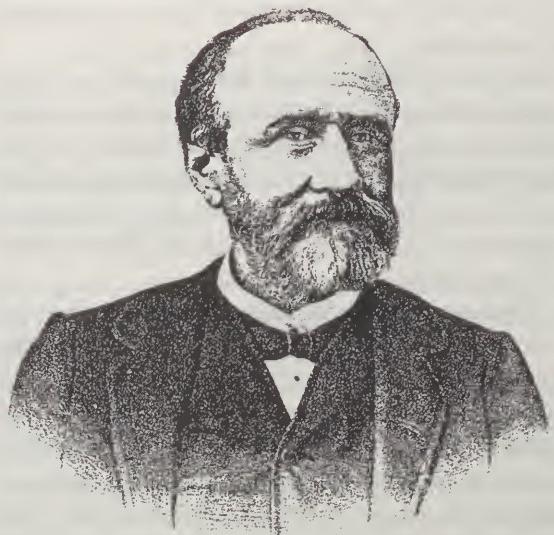
Before departing for military duty, Dr. Isom installed false shelves between the master bedroom and the nursery in his home. There he hid most of his medical supplies. These were not discovered by General Grant and his soldiers, and shortly after the close of the war, during the yellow fever epidemic of the 1870s, ever the dedicated physician, Dr. Isom traveled to Memphis with these medicines. The story goes that there were so few medical supplies available during the time immediately after the war that Dr. Isom kept Memphis from being decimated by yellow fever.<sup>2</sup>

Only a few homes in Oxford were spared, one of them, Isom Place. General Grant had kept his word.

The University officially reopened the first Monday in October 1865, three years and eleven months after the war had closed its doors. Only 24 of the 135 University Greys who had signed up survived. None returned to Oxford for study. The memorial to them on the campus-a large stained glass window in a classroom building-reflected the reverence for tradition and fealty to place that would inform and inflame later crises on campus; “in honor of those who with ardent valor and patriotic devotion to the Civil War sacrificed their lives in defense of principles inherited from their fathers and strengthened by the teaching of their alma mater.”<sup>3</sup>

Dr. Isom’s military activities were not limited to the hospital at Oxford. He also served as the military surgeon in the fall and winter of 1862 at Jackson and Columbus, Mississippi. In 1863 he was appointed to the Army Medical Board and continued in this capacity until the close of the war. The Medical Board was an extremely important organization which helped to weed out incompetent medical officers. Dr. Isom was said to have the distinction of being the oldest and most extensive practitioner in Northern Mississippi in all branches of his profession. He was the first to demonstrate in this locality the possibility “of treating febrile illnesses of malarious and malignant type (malaria) with large doses of quinine, and omitted venesection and depletion.” He enjoyed remarkable success in surgery, “having extirpated the superior maxillary bone in 1856, patient still living, and many successful operations in all of the hernias.” And his operations in extirpating tumors have been extensive.” He was the first in his locality to apply Sayre’s plaster jacket in Pott’s disease.<sup>1</sup> He was in 1877 appointed -a member of the Mississippi Board of Health.<sup>8</sup> (Figure) He was a member of the Secession Convention in 1880, and the Constitutional Convention in 1890.<sup>1</sup>

Dr. Isom was active in organized medicine. In 1869 he was elected vice president of the Mississippi State



*Thomas D. Isom*

Thomas D. Isom, M.D.

Medical Association which was being reorganized after the war. He also was elected a delegate to the American Medical Association which was to meet in New Orleans in 1883.<sup>8</sup>

Nine children were born to his wife and him. One of Dr. and Mrs. Isom’s children was Sarah McGehee Isom (1852-1905). She was the first woman faculty member at the University of Mississippi or any other Southern university.<sup>2</sup> A building on the Ole Miss campus is named for her.

On Saturday, 5 May 1902, Dr. Isom was said to be in his usual health and drove several miles in the country. On his return he took dinner with his sister, Mrs. T.L. Harris of Oxford. He slept well Saturday night, arose at the customary hour Sunday, ate his breakfast, but was taken severely ill in a few moments. He expired in less than an hour.<sup>9</sup> The *Oxford Eagle* stated, “Never since the re-interment of Chief Justice Lamar, six years ago, has a larger funeral procession followed the remains of a loved one to the cemetery. The *Eagle* tenders heart-felt sympathy to the bereaved children and grand-children of this truly great and good man. “This source gave as cause of death heart failure.

He was also said at the time of his death to be the oldest practicing physician in the state.<sup>9</sup> Another source stated, "He was in his eighty-seventh year and wonderfully preserved for his age."<sup>9</sup> This source gave the cause of his death as apoplexy.<sup>10</sup>

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**Harris D. Riley, Jr., M.D. and Frank A. Riley, J.D.**  
are brothers. They are related to the late Dr. Thomas D. Isom. Dr. Harris Riley is Professor of Pediatrics at Vanderbilt University Medical Center.

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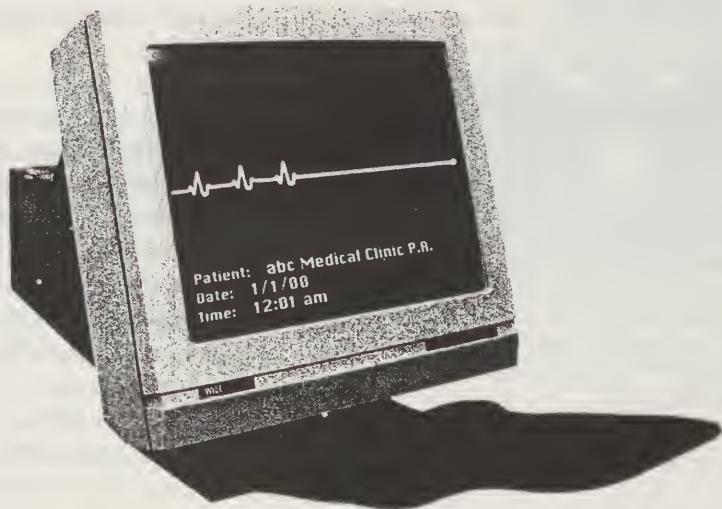
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# The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice

*[This is the second of a continuing series of excerpts published with permission from *The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice*, published by the American Medical Association, 1999. —Ed.]*

## Liability of Corporate Officers and Directors

### I ntroduction

Many physicians serve as directors and/or officers of their professional corporations. Directors and officers have a legal obligation to act diligently and prudently in directing, managing, and operating the business and affairs of their corporation. This obligation requires directors and officers to respond appropriately to the Year 2000 problem. Directors and officers that fail to do so may find themselves personally liable for the damages suffered by their corporations. (Note that the discussion below would also apply to any other proprietary or nonprofit corporation for which a physician served as a director and officer. It is also generally applicable, at least by analogy, to medical practices organized as limited liability companies and limited liability partnerships. Liability exposure extends to all partners, not just to those in management positions, in a medical practice organized as a general partnership.)

In general, state corporate law imposes on directors and officers the fiduciary duties of "loyalty" and of "care." The duty of loyalty requires directors and officers to act always in the best interests of the corporation

rather than themselves. The duty of care requires directors and officers to act with attention and prudence with regard to the affairs of the corporation. In general, the duty of loyalty is unlikely to be the source of much litigation arising from the Year 2000 problem. The duty of care, however, is very much implicated by the Year 2000 problem, and most lawsuits against directors and officers likely will be based on allegations of a breach of this duty. The following recommendations, if followed, will both serve to maintain the quality of patient care in your organization and reduce the risk of liability for directors and officers:

### Know Your Responsibilities/Duties as a Director or Officer

**Duty of Care/Business Judgment Rule.** Although state laws vary somewhat, the Revised Model Business Corporation Act sets forth a standard of care that applies in most states. It requires directors and/or officers to act (a) in good faith, (b) with the care of an ordinarily prudent

person in a similar position, and (c) in a manner they reasonably believe to be in the corporation's best interest. (State statutes sometimes apply this standard expressly only to directors, but it is probably the standard that would be applied by a court or arbitrator to officers as well. For simplicity, we will refer below only to directors.) The duty of care obligates directors to consult and consider sufficient information to be able to make well-informed business decisions. Directors may rely on the advice of outside experts, however, as long as such reliance is warranted under the circumstances and the director has no reason to question the advice. In addition, the duty of care requires directors to inquire as to and monitor the corporation's activities. Directors cannot simply blind themselves to the activities, or lack thereof, of the corporation. Under the "business judgment rule" that exists in most states, if a director makes a decision in good faith and after considering all relevant material information relating to the matter, he or she will generally be protected from personal liability even if his or her decision turns out to be a wrong one. Thus active attention to the affairs of the corporation is the director's best legal protection.

### **Act to Satisfy Your Duty of Care**

In order to satisfy your duty of care as a director (or officer) of a corporation, you will be required to respond appropriately to the Year 2000 problem. A failure to provide a well-informed response to the problem will subject you to a risk of being held personally liable for any resulting damages or losses to the corporation. In contrast, a well-informed response to the Year 2000 problem will likely avail you and your fellow directors and officers of the protections afforded by the business judgement rule. The following are all steps that can and should be taken to help satisfy your duty of care with respect to the Year 2000 problem:

**Education.** Ensure that you are educated on the Year 2000 problem in general, and how it might affect patients and the corporation in particular. Although special educational meetings for the directors and officers for this purpose may be appropriate, the Year 2000 problem should also be an ongoing agenda item at regular board meetings.

**Year 2000 Committee.** A Year 2000 committee, charged with the design, implementation, and day-to-day oversight of the corporation's Year 2000 compliance efforts, should already be in place. If no committee is yet in place, one should be formed immediately. The board

should regularly review the composition, purposes and activities of the committee and should either ratify the formation and activities of the committee to date or make appropriate modifications.

**Receive Regular Reports.** The board should receive regular reports from the Year 2000 committee and should insist that the committee advise the board promptly and periodically of the status of compliance efforts. The board should review and then formally ratify, or make appropriate modifications to, the recommendations of the committee. If the committee is not carrying out its duties appropriately, the board should take remedial action.

**Consider the Year 2000 Compliance Plan.** The corporation should have, and the board should consider and approve or modify, a Year 2000 compliance plan. Directors should be given a reasonable amount of time to review the plan and to consider all available information. They should not simply "rubber stamp" the plan, but rather should make reasonable inquiries into assumptions, budgets, recommendations, and time frames in the plan. The board may even consider hiring its own outside technical consultant to provide it with independent advice on the adequacy of the plan. (A small physician practice with limited time and resources may not have a formal, written compliance plan. Nonetheless, the officers and directors of such a practice should still act to ensure that the steps taken to address the Year 2000 problem are appropriate, timely, well-documented and maintained centrally.)

**Assure Proper Prioritization of Compliance Efforts.** The board should assure that the corporation's efforts to address the Year 2000 problem are focused initially on preventing harm to patients and continuity of other critical functions of the corporation. While significant adverse operational impacts may occur in systems deemed "non-critical," adhering to your prioritization of effort (and periodically reassessing that prioritization) is essential.

**Ensure Appropriate Cost Recoveries.** The board should make sure that the corporation is preparing adequately to pursue avenues to recover (eg, through insurance and appropriate legal action) costs incurred by the corporation as a result of the failure of others to solve their Year 2000 problems, and of the corporation to remedy its own Year 2000 problems.

**Due Diligence.** The board should make sure that

the Year 2000 problem is included in any "due diligence" of a proposed merger or acquisition target, and of any proposed new supplier or vendor. Any Year 2000 issues that are revealed in the due diligence should be taken into account in negotiating the relationship or transaction.

**Document Meetings.** The board should ensure that all of their meetings at which the Year 2000 problem is discussed are well documented.

## Act to Minimize Personal Liability for Year 2000-Related Acts and Omissions

**Be Aware of the Ability to Obtain Indemnification from the Corporation.** Since the 1980's, most states have added provisions to their corporate laws that either permit or even mandate the indemnification of directors against liability by their corporations in many circumstances. If your state's laws are merely permissive, you may wish to request your corporation to commit to such indemnification.

**Obtain Director and Officer Insurance.** Almost all state corporate laws permit, but do not require, corporations to purchase and maintain director and officer insurance ("D & O insurance"), including in some states self-insurance. You may wish to request that your corporation obtain such insurance. However, it is important to note the following with respect to D & O insurance:

- Since many D & O policies are issued as "claims made" policies, they will not serve as a source of recovery for any claims made as a result of the Year 2000 problem unless coverage is continued well into the next century. Thus, corporations should be sure to either maintain their existing policies for the next several years or obtain "tail" coverage.

- Many D & O policies carry a large deductible. Whether the corporation itself or the director or officer is responsible for paying the deductible will depend on what other arrangements, if any, the corporation has made to protect its directors and officers.

- D & O policies contain a variety of exclusions. Corporations should review any existing or proposed policies to determine whether a claim based on the Year 2000 problem might fall within one of the exclusions, and hence not protect the director or officer. In addition, corporations should monitor amendments to the D & O

policies issued by the carrier to ensure that specific exclusions are not added for the Year 2000 problem.

- Corporations and their directors and officers should review their applications for D & O insurance to verify that all disclosures have been made and that the insurer has no grounds to refuse payment based on misrepresentation in the application.

## Criminal Liability

### Introduction

Although the potential for civil litigation arising from the Year 2000 problem has been widely discussed, little has been said thus far about the potential for criminal liability stemming from the Year 2000 problem. Nevertheless, in situations in which death, serious physical injury, substantial property damage or significant financial loss occurs as a result of a Year 2000-related system failure, public prosecutors may well initiate criminal actions against those they deem responsible. The individuals or entities most likely to face such prosecution are those that have failed to take reasonable steps to (1) eliminate or minimize the organization's Year 2000 problem and consequently, harm to others, or (2) find an alternative to utilizing Year 2000 compromised systems in situations in which the reliability of the system is in doubt.

### Understand Possible Bases of Criminal Liability

- **Criminal Liability for Reckless or Negligent Behavior.** All states have statutes that can impose criminal liability upon those whose reckless or negligent behavior causes death or injury. Such crimes carry significant penalties. No intentional act is required. In addition, in most states a person can be guilty of a crime, eg, "reckless homicide," by acts of omission as well as commission. Thus, in the event of injury or death resulting from a failure to check a device for Year 2000 compliance (eg, a patient receiving an overdose of medication administered by a non-Year 2000-compliant infusion pump), it is not at all unlikely that the justice system would look for someone to potentially hold criminally responsible. In such situations, those who knew or had reason to know that a computer system was not reliable because of a Year 2000 problem (or any other problem) and failed to correct

the problem (eg, to develop an alternative to the use of the non-compliant system) are likely targets for prosecution.

- **Criminal Liability for “Infecting” Compliant Systems.** Most computers communicate regularly with other computers or computer systems. A computer system that is not Year 2000 compliant could cause a compliant system to fail, or otherwise cause damage to that system. The owner of the non-compliant system could probably be sued civilly. In addition, however, the owner of the compliant system could demand action from a local prosecutor in the form of a charge of “criminal damage to property.” In addition, under federal law one who knowingly causes the transmission of damaging program information or code to a “protected” computer, eg, a government or financial institution computer, is guilty of a felony.

- **Criminal Liability for False Billing.** The Year 2000 problem could result in your practice inadvertently submitting inaccurate billing claims. The Social Security Act, Health Insurance Portability Act, Program Fraud Civil Remedies Act and Federal False Claims Act each has a variety of civil and/or criminal penalties that may be imposed for submitting “false claims.” Although most statutes restrict criminal charges to “knowingly” submitting a false claim, this may not require a specific intent to defraud. Instead, there may be criminal liability if a physician submits a Medicare or Medicaid claim while acting in “deliberate ignorance of” or “reckless disregard for” the truth or falsity of the information in the claim. As a result, your failure to identify and address Year 2000 issues in your billing systems could lead to criminal liability if inaccurate claims result. Civil penalties would be even more likely to be imposed.

## Act to Ensure Year 2000 Compliance in Your Billing Systems

**Submitting Claims.** All necessary steps should be taken to attempt to achieve Year 2000 compliance in this area. In addition, consider implementing an alternative electronic billing system that you know is Year 2000 compliant (depending on the complexity of your system there may not be sufficient time remaining to successfully implement such a solution). Outsourcing or a manual backup billing system are additional alternatives. Such a system must include a mechanism for retrieving charge information from individual patient records, moving that information to appropriate billing forms, and mailing

those forms in a timely fashion to the appropriate payors. Consider using such a backup system, for all bills for which payment will be due in Year 2000, until the primary electronic billing system is determined to be Year 2000 compliant or through the first quarter of 2000, whichever is later. After any claim is submitted, verify its receipt by the payor.

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[The following Board Report will be considered at the upcoming meeting of the MSMA House of Delegates. It is being published prior to the 131st Annual Session, May 14-16, 1999, so that physicians may have time to carefully review it. —Ed.]

Mississippi State Medical Association  
131st Annual Session  
Biloxi, Mississippi      1999

Report F of the Board of Trustees

SUBJECT: Resolution No. 7 and Report of the Council on Medical Service  
(Scope of Practice Infringement by Non-Physicians)

FROM: Chester W. Masterson, M.D., Chair

REFERRED TO: Reference Committee A

**Background:** At the 130th Annual Session in 1998 the Report of the Council on Medical Service and Resolution No. 7 directed the Board of Trustees to expand efforts to protect the practice of medicine from scope of practice infringements by non-physicians. The Board subsequently discussed this matter at both its August and December 1998 meetings. As part of that effort, all of the various Mississippi laws dealing with non-physician scope of practice were reviewed by the Board.

**Discussion:** Traditionally, organized medicine has dealt with scope of practice issues by opposing legislation that would expand the practice of non-physicians. For many reasons, this is becoming more and more difficult to accomplish as the number of such practitioners continues to grow and they increase their influence with legislators. Additionally, attempting to influence what other practitioners may or may not legally do is risky, confrontational and appears to outsiders to be motivated solely by economic "turf" issues. This frequently results in alienating the potential support that might be needed from these groups and their supporters on other issues. Consequently, defeating legislation may not always be feasible and medicine must begin to explore alternative means of accomplishing its objectives in this area. Two of those considered by the Board were:

1. *Establishing professional standards that would govern the relationship between physicians and non-physicians, since organized medicine has some ability to influence the behavior of the former and practically none with regard to the latter.* Although MSMA will continue to oppose inappropriate attempts by non-physicians to expand their scopes of practice, in those instances where outright defeat of such legislation may not be practical or possible, a secondary objective will be to maintain ultimate physician control over the exercise of such expanded practices through the use of a protocol arrangement between the supervising physician and the non-physician practitioner. Although the basis for both nurse practitioner and pharmacist expanded roles is the protocol arrangement with a supervising physician, not all physicians take this responsibility as seriously as others. In order to take full advantage of the authority afforded by this process, it will be necessary for medicine to develop a set of guidelines that would define the professional responsibility of the collaborating physician. The essential hallmark of this professional standard is that the physician should at all times be fully responsible for the care of patients seen by him or someone working under his/her supervision and that this responsibility may not be delegated to someone else. These standards could then be provided to medical liability insurers and health insurance plans, and enforced by the association as a requirement for membership under Principle I of the Principles of Medical Ethics, which states that "a physician shall be dedicated to providing competent medical service with compassion and respect for human

dignity."

2. *The public should be informed on a regular basis of the differences in education, training and capabilities of physicians and non-physician practitioners.* A comprehensive and ongoing educational campaign directed at the public, members of the legislature and regulatory agencies could help clarify some of the important differences between various health care providers. This could ultimately lead to more informed and thoughtful choices about whom a person elects to entrust their health care. Perhaps the most significant impact of such a public education effort would be the promotion of professionalism in the practice of medicine. The association could seek collaborative partnerships with others, such as pharmaceutical manufacturers, in funding and developing this effort. The Board elected to pursue these two initiatives in forming the basis for its recommendations to the House of Delegates on implementing the directives regarding a more aggressive posture on scope of practice issues. Development of the professional guidelines governing collaborative relationships with non-physicians was assigned to the Council on Medical Service. Over the course of two meetings the Council subsequently developed a draft set of professional standards for physician/non-physician relationships. The Board has considered these draft standards on two occasions and sought the input of the Mississippi State Board of Medical Licensure. These standards are now being presented to the House of Delegates for discussion and adoption.

**Recommendation:** That the House of Delegates (1) adopt the proposed "Professional Standards Governing Physician and Non-Physician Relationships" included with this report, and (2) implement an educational campaign designed to inform the general public, legislators and others about the difference in education, training and capabilities of physicians and non-physician practitioners.

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### **Professional Standards Governing Physician/Non-Physician Relationships**

*Report from the Council on Medical Service, November 1998*

#### **Physician Responsibility**

The physician is responsible for managing the health care of patients in all settings. Physicians must always retain authority for patient care in any team care arrangement to assure that patient safety and quality of care are priority. The goal of any team arrangement must be to improve patient care. Appropriate team arrangements, integrated practice arrangements or collaborative practice arrangements referenced herein shall be limited to formal physician/nurse practitioner or physician/pharmacist agreements fully delineated in a written protocol signed by the physician and the non-physician and approved by the State Board of Medical Licensure. For purposes of these guidelines the term "physician" means only "medical doctor" or "doctor of osteopathy."

- The physician should present and discuss the protocol and obtain approval from the SBML to act as a supervising physician any time the physician will not be able to provide on-site supervision of the non-physician.
- Evidence of the physician's liability insurance covering supervision of non-physicians via protocols should be submitted to the SBML.
- No physician should enter into a protocol outside the physician's specialty or area of practice.
- Physicians and back-up physicians should possess active staff privileges at one or more hospitals within a 50-mile limitation.
- The written protocol should always be available at the practice site of both the physician and the non-physician for reference and referral. The protocol should be supplemented with job descriptions and written contracts as appropriate.

*... continued on page 187*



## Looking Back as Your President

### Michael H. Carter, Jr., M.D. The President's Page

**F**or the 12th time in as many months I have committed words to paper to share my thoughts on the state of our art. Each month I pondered topics that I thought would have meaning for physicians. Each month, that is, except this one.

Since my first month serving as President of MSMA I have known what the topic of this column would be. All these months I've thought about incidents that I could relay to make my point. As I traveled across the state to visit component society meetings and as I sat across the table to work out a problem with Medicaid officials, I added to my repertoire. Now, I find, there's not enough room to tell all the funny stories. So, instead, I must use this space to salute a couple of unsung heroes.

My commitment to organized medicine is not solely my own. It is shared by a lot of other folks. This column is dedicated to them, to the colleagues and loved ones behind the scenes who take up the slack so a doctor like me can fulfill the responsibilities of office. Throughout organized medicine, in specialty societies, state associations and at the AMA level, there are partners and colleagues who do yeoman's work covering practice schedules, taking on extra cases and seeing that the practice runs smoothly. In my case, this was my partner Jeff Lambdin.

Jeff always managed to rearrange the schedule when I needed to be away on MSMA business. He's a great doctor and a good friend, and I truly appreciate his willingness to cover for me at the office.

To my colleagues on the hospital medical staff I say, "Thanks." Without their ever present guidance and wisdom my job as president would have been much more difficult. I never had to wonder what impact an action would have on other doctors – they caught me the minute I set foot in the hospital and were quick to point out the good and the bad in each endeavor.

I can't leave out Jo Taylor, my nurse who kept track of me, kept me on track and covered my tracks. Jo's pleasant nature and cheerfulness helped to make my year as president enjoyable despite the hectic schedule. Though I should thank many individual members of the MSMA staff – they know who they are – I could not in good conscience fail to thank Charmain Thompson who has taken me on as a special project this year.

Throughout the year, always by my side, was Mary Rose. She and our children, Clare and Walker, saw less of me while I was tending to MSMA business. They've supported me in every way and were understanding when business changed our family plans.

This column is dedicated to these friends, my family, my staff and my colleagues, who made it possible for me to serve as MSMA president. Know that I appreciate and respect your contributions.

A handwritten signature in cursive ink that reads "Mike Carter".

# Editorials

JOURNAL OF THE  
MISSISSIPPI STATE MEDICAL ASSOCIATION  
VOLUME XXXX, NUMBER 5  
MAY 1999

## I'VE DISCOVERED THE CURE FOR BURN OUT, AND I WON'T CHARGE YOU FOR IT, EITHER

These can be discouraging times in medicine, if one dwells on them. Stories of doctors applying for disability at the first misery in their backs, or others quitting in frustration to run marinas are not hard to find. Probably, though, every generation has had its serious problems. I've read the proceedings of the MSMA annual session for 1904 and can tell you that not only did they have to take a buggy to get to the hospital for rounds, they agonized over the problem of tuberculosis, a disease not only for which they had no treatment but also representing a dangerous hazard of contagion to themselves. And don't forget that their fathers had to perform surgery under shell fire at Vicksburg.

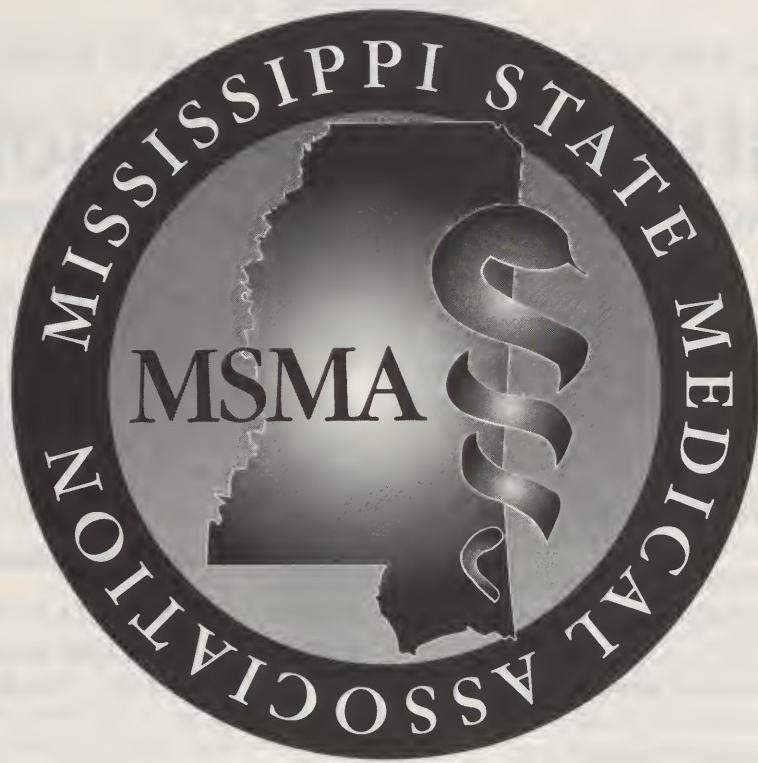
So what's my cure for burnout? When I, like everyone else, get discouraged or overwhelmed, I go back to my roots. That for me was in the medical school library at lunch when I first discovered the clinico-pathologic conference from the Massachusetts General Hospital in "The New England Journal of Medicine." I marveled at the logical series of deductions, the calculated probabilities, used to unravel these perplexing cases. I was always going to be an internist. On reaching my third year, I was sorry to see the medicine rotation scheduled as my last of the year. So I chafed at the pediatricians whose pockets rattled with the aspirin needed for the incessant screaming on the wards, at the obstetricians who presumed an understanding of the secrets of the womb, at the coarse humor of the surgeons.

I still read the Case Records of the Massachusetts General Hospital (no, they haven't changed their name to medical center.) Especially if I'm in a rut, I read them--numbers of them if I'm really stuck. And the magic comes back. Every time.

It's called dancing with the one what brought you, and it's a different one for each of us. It means that on the next day when a patient looks at you with the desperation of the doomed, and they see in your face you haven't enough to offer, you will know you have done your dead level best.

— *Leslie E. England*  
*Editor*

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*



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**May 14 - 16, 1999  
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**Supplement to The Journal of The Mississippi State Medical Association, May 1999**



# GENERAL INFORMATION

## REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in all references committees as policies of the Association are established. All meetings will be held consecutively.

The schedule is as follows:

2:00 PM	Reference Committee on Constitution and Bylaws
2:30 PM	Reference Committee A
4:00 PM	Reference Committee B

## CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours for this session will be listed in the official program of the 131st Annual Session.

## MSMA ALLIANCE PROGRAM

The MSMA Alliance will hold its 76th Annual Session Meeting, May 14-16, at the Grand Hotel & Resort. A copy of the meeting agenda is enclosed with the Distaff.

Members and their spouses are invited to all social events which are all complimentary except the MSMA / MSMA Alliance reception and dinner featuring the Sotiles.

## THE PRESIDENT'S RECEPTION

The annual President's Reception will be held Friday evening, May 14, in the Ballroom of the Grand Bayview Hotel in Biloxi, from 6:30 PM to 8:00 PM. Tickets will be provided for a live performance in the Grand Theatre, which is adjacent to the hotel, following the reception. However, the name of the show has not been announced at this time.

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## MSMA/ MSMA ALLIANCE MEMBERSHIP PARTY TO FEATURE GUEST SPEAKERS WAYNE SOTILE, PH.D. AND MARY SOTILE, M.A.

The MSMA/MSMA Alliance Reception and Dinner will be held on Saturday evening, May 15, at 6:30 PM in the Grand Bayview Ballroom. An added attraction will be guest speakers Wayne Sotile, Ph.D. and his wife, Mary, co-authors of the groundbreaking book, *The Medical Marriage: A Couple's Survival Guide*, a fast-paced, humorous and compassionate look at the unique challenges that face today's physicians and their loved ones. The Sotiles will speak on "Managing the Stress of Medicine and Personal Relationships." Based on their experiences counseling over 600 physicians and their families, the Sotiles offer practical ways to maintain stress resilience as a medical family and enjoy each other in the process. Admission tickets will be available for \$25.00 per person to offset the costs for these nationally recognized speakers. The MSMA Alliance will once again hold a silent auction with proceeds benefiting the AMA Foundation. Association members and guests will have the opportunity to browse through the items for auction and make their silent bid before dinner. All items will be sold before the conclusion of the party.

# **MSMA 131st Annual Session and Scientific Assembly**

**May 13-16, 1999**

**Grand Hotel Resort • Biloxi, MS • 1-800-354-2450**

**Deadline for Guaranteed Reservations: April 15, 1999**

## **PRELIMINARY SCHEDULE**

### **THURSDAY, MAY 13**

1:00 p.m. Exhibitor set-up  
Registration  
1:00-4:30 p.m. Media/Speakers Training-Pat Clark  
4:30 p.m. Board of Trustees Meeting

### **FRIDAY, MAY 14**

7:30 a.m. Continental Breakfast with Exhibitors  
Specialty Society Breakfasts:  
MS Section of the American  
College of Obstetricians and  
Gynecologists  
MS Eye, Ear, Nose & Throat Association  
Registration  
8:00 a.m. Reference Committee Members Breakfast  
House of Delegates  
11:00 a.m. Lunch with Exhibitors  
Board of Trustees Meeting  
12 noon Alliance Pre-Convention Meeting  
YPS Business Meeting  
MMPAC Board of Directors Meeting  
Cooperative Actions for Health Program  
(CAHP) / Medicine Public  
Health Initiative Program  
12:30 p.m. MPIC Stockholders Meeting  
Reference Committee on Constitution and  
Bylaws  
2:00 p.m. Reference Committee A  
Reference Committee B  
6:30 p.m. President's Reception  
8:00 p.m. Grand Theatre Live Performance  
"Las Vegas Nights"  
9:30 p.m. Southern Medical Association Coffee and  
Dessert Party

### **SATURDAY, MAY 15**

7:00 a.m. Women in Medicine Breakfast  
7:30 a.m. Registration  
Continental Breakfast with Exhibitors  
Board of Trustees Meeting  
Specialty Society Breakfasts:  
MS Chapter of the American College  
of Surgeons  
Mississippi Society of Anesthesiologists  
Past President's Breakfast  
Fifty-Year Club Breakfast  
8:30 a.m. Plenary Session  
Alliance Welcome and Coffee  
9:00 a.m. MS State Dermatology Society Meeting  
11:30 a.m. Alliance House of Delegates Meeting  
Alliance Luncheon  
Specialty Luncheons:  
MS Academy of Family Physicians  
MS Chapter of the American College  
of Surgeons  
MS Society of Anesthesiologists  
MS Neurological Association  
12 noon Plenary Session  
4:00 p.m. Component Society Caucuses  
5:00 p.m. MACM Reception  
5:30 p.m. University of Mississippi Alumni  
Reception  
6:30 p.m. MSMA/MSMA Alliance Cocktail  
Reception, Dinner and  
Silent Auction (Dinner speakers:  
Wayne Sotile, Ph.D. and Mary O.  
Sotile, M.A.-"Managing the Stress of  
Medical and Personal Relationships")

### **SUNDAY, MAY 16**

7:00 a.m. Board of Trustees Meeting  
Continental Breakfast for Members  
8:00 a.m. Worship Services  
8:30 a.m. Alliance Past-Presidents' Breakfast  
9:00 a.m. House of Delegates  
12 noon Board of Trustees Meeting and Lunch  
Mississippi Association of Pathologists  
Meeting and Lunch (12-3:00 p.m.)

# **"MEDICAL PRACTICE IN A HIGH IMPACT SOCIETY" EDUCATIONAL PROGRAM**

(PRELIMINARY SCHEDULE)

## **PLENARY SESSION**

SATURDAY, MAY 15 • OASIS BALLROOM

8:30 A.M. **PANEL: "THE TREATMENT OF CHRONIC AND INTRACTABLE PAIN"**

•**CLINICAL PERSPECTIVE**

C. Anne Myers, M.D., Director

The Pain Clinic, Jackson, Mississippi

•**REGULATORY PERSPECTIVE**

W. Joseph Burnett, M.D., Executive Officer,

Mississippi State Board of Medical Licensure

9:45 A.M. **"SPORTS MEDICINE UPDATE"**

William B. Geissler, M.D., Associate Professor,

University of Mississippi School of Medicine

Department of Orthopedic Surgery

10:30 A.M. **"BUILDING A STATEWIDE TRAUMA SYSTEM IN MISSISSIPPI"**

•**PROGRESS REPORT**

Ed Thompson, M.D., State Public Health Officer

Mississippi State Department of Health

•**ESSENTIAL COMPONENTS FOR HOSPITALS AND MEDICAL STAFFS**

Frank Ehrlich, M.D., Chairman

Department of Surgery, St. Joseph's Hospital

Patterson, New Jersey

11:30 A.M. **LUNCH BREAK**

1:00 A.M. **"UPDATE ON ORGAN TRANSPLANTATION"**

- Sponsored by Mississippi Organ Recovery Agency (MORA)

•**A RECIPIENT'S PERSPECTIVE**

Phil Berry, Jr., M.D., Past-President,

Texas Medical Association

•**THE MISSISSIPPI ORGAN RECOVERY AGENCY (MORA)**

Shirley D. Schlessinger, M.D., Associate Professor

University of Mississippi School of Medicine

Department of Internal Medicine

2:30 P.M. **"MINIMIZING THE TRAUMA OF LITIGATION"** - Sponsored by MACM

(Speaker unconfirmed at press time, to be announced in next program)

3:15 P.M. **"HEALTH CARE LEGISLATION AND THE 106TH CONGRESS"**

Julius Hobson, Director of Congressional Affairs

American Medical Association

4:00 P.M. **ADJOURN**

**PLENARY PROGRAMS PLANNED BY MSMA's:  
COUNCIL ON SCIENTIFIC ASSEMBLY**

## **PLAN TO ATTEND 131st ANNUAL SESSION**

**Biloxi Grand Hotel & Resort • May 13-16, 1999**

### **MSMA / MSMA Alliance Reception & Dinner Featuring the Sotiles**

**"Managing the Stress of Medical and Personal Relationships"**  
**6:30 p.m., Saturday, May 15, 1999**



**Mary Sotile, M.A. and Wayne Sotile, Ph.D.**

The MSMA/MSMA Alliance Reception and Dinner will be held on Saturday evening, May 15, at 6:30 PM in the Grand Bayview Ballroom. An added attraction will be guest speakers Wayne Sotile, Ph.D. and his wife, Mary, co-authors of the groundbreaking book, *The Medical Marriage: A Couple's Survival Guide*. This book presents a fast-paced, humorous and compassionate look at the unique challenges that face today's physicians and their loved ones. The Sotiles will speak on "Managing the Stress of Medicine and Personal Relationships." Based on their experiences counseling over 600 physicians and their families, the Sotiles offer practical ways to maintain stress resilience as a medical family and enjoy each other in the process. Admission tickets will be available for \$25.00 per person to offset the costs for these nationally recognized speakers.

Wayne and Mary Sotile are among the most sought-after keynote speakers and consultants today. A pioneer in the field of health psychology, Dr. Sotile has served for twenty years as Director of Psychological Services at the Wake Forest University Cardiac Rehabilitation Program. He and his wife, Mary, have co-directed a thriving psychological practice. Dr. Sotile has consulted with over 400 organizations, corporations and health care systems, including: The Million Dollar Round Table, Sarah Lee Corporation, Medtronic, Inc., Bayer Pharmaceuticals, Westinghouse, Inc., the American Academy of Orthopaedic Surgeons, and the American Medical Association Alliance. He has addressed countless professional and lay audiences on the secrets of stress-resilient individuals, couples, families, and businesses.

The MSMA Alliance will once again hold a silent auction with proceeds benefiting the AMA Foundation. Association members and guests will have the opportunity to browse through the items for auction and make their silent bid before dinner. All items will be sold before the conclusion of the party.

**For more information about the Sotiles and to register complete and return the form found reverse.**

# **PRESENTING THE SOTILES**

## **"Managing the Stress of Medical and Personal Relationships"**

**6:30 p.m., Saturday, May 15, 1999**  
**Reception and Dinner**  
**Admission \$25.00**

"With Cajun charm and the wisdom of Mark Twain, Wayne Sotile is a delight for anyone interested in today's relationships." — Lori Gordon, Ph.D., Founder of Practical Application of Intimate Relationship Skills (PAIRS)

"The Sotiles help you laugh, learn and thrive while you live your BIG LIFE." John C. Campeau, Jr. — Host of ABC's Good Morning Connecticut Business Brief

"I learned more in the last hour than I did in \$30,000 of marital therapy, a terrific presentation!" — Surgeon, Cardiovascular Administrator's Conference, Irvine, California

"Dr. Sotile speaks to the heart and soul of credibility and integrity in personal and business relationships." — Gary York, President of York Oil Company and Neighbors Stores

"With wisdom, humor and personal examples, Mary and Wayne Sotile show how any couple can develop stress resilience and find new levels of intimacy in marriage." — David & Sara Catron, Ph.D.s, Executive Directors, Association for Couples in Marriage Enrichment (A.C.M.E.)

"Wayne Sotile could motivate a stick to change!" — Mona Lisa Schulz, M.D., Ph.D., Psychiatrist and Author

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**Complete and mail registration form to:**

**Barbara Shelton  
Mississippi State Medical Association  
P. O. Box 5229  
Jackson, MS 39296-5229**

*Make check payable to Mississippi State Medical Association.*

**Registrant (please print or type)**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ # of tickets \_\_\_\_\_

Spouse / Guest \_\_\_\_\_

*Tickets may be picked up at the MSMA registration desk in the Grand Lobby.*



# Mississippi State Medical Association Alliance

**76th Annual Session  
May 13-16, 1999  
Grand Hotel & Resort  
Biloxi, MS**

## **THURSDAY, MAY 13**

1:00 AM - 4:00 PM      Registration - 2nd Level

## **FRIDAY, MAY 14**

8:00 AM - NOON      Registration - 2nd Level  
12:00 PM      Pre-convention Board Meeting/Luncheon  
6:30 PM      MSMA President's Reception

## **SATURDAY, MAY 15**

8:30 AM      Alliance Welcome and Coffee  
9:00 AM      House of Delegates  
11:30 AM      Luncheon/ Installation of Officers  
1:00 PM - 5:00 PM      View AMA-ERF Auction items  
2:00 PM      Post-convention Board Meeting  
6:30 PM      MSMA/ MSMAA Cocktail Reception, Dinner  
& AMA Foundation Auction (Dinner speakers: Wayne Sotile,  
Ph.D. and Mary O. Sotile, M.A.-“Survival Guide for the  
Medical Marriage”)

## **SUNDAY, MAY 16**

8:30 AM      MSMAA Past Presidents' Breakfast

## Information and Quality Healthcare Update

### Influenza Immunization Project

I.Q.H. has been working with collaborators and partners for five years to increase the number of influenza immunizations in the state.

The goal set for the year 2000 in the fight against influenza is to maintain the 60 percent immunization rate for persons over 65. According to recent statistics, Mississippi's flu immunization rates for this group have improved from 42.4 percent in 1993 to 61.1 percent in 1997.

These statistics come from the Behavioral Risk Factor Surveillance System (BRFSS), which is a random digit-dialed telephone survey of adults. The latest BRFSS survey shows that the United States influenza immunization rate for persons 65 years old and older is 65.9 percent.

We are pleased with the over-60 percent measurement in 1997; we want to sustain this improvement. This past fall and winter's I.Q.H. campaign focused primarily on the 27 southern-most counties in the state. We are optimistic about seeing the rates increase as we receive the results of these recent efforts.

We plan to continue seeking a still-higher rate of immunization, working with the Health Care Financing Administration, the Mississippi State Health Department, physicians, hospitals, pharmacists and other partners and supporters which include such groups as churches, schools, and associations.

### Quality Forum June 4 and 5

The I.Q.H. annual physician membership meeting is scheduled for June 5 in Jackson. It will be held in conjunction with the two-day Quality Forum to be held at the University Club.

The session will begin shortly after the lunch program Saturday which will feature well-known physician, author and medical researcher Dr. Neil Shulman of Decatur, Ga., who is also "Doc Hollywood." His novel was made into a film in 1991, and he should be a highlight for the Forum. He will also be present for a Friday evening, June 4, reception which will be a fund raiser for the I.Q.H. Foundation.

The Derrick Award for outstanding physician support of quality will be made at the annual session.

Friday's Quality Showcase will feature the following events in the morning portion of the program:

Dr. Michael R. McMullin presenting "Treatment of Acute Myocardial Infarction and Management of Heart Failure"

Dr. Richard D. deShazo, "Inpatient Pneumonia--Antibiotic Selection and Timing"

Dr. Al Rousa, "Preventive Health Measures: Influenza/Pneumococcal Vaccinations/Mammography"

Dr. Robert Evans, "Outpatient Management of Diabetic Patient"

Dr. David Lee Gordon, "Prevention and Treatment

of Stroke/TIA."

During the luncheon session Friday, June 4, the annual Quality Awards will be announced. These awards recognize hospitals whose projects have demonstrated outstanding efforts in improving the quality of care for Medicare beneficiaries in the state.

The afternoon lineup will feature "Serving You Better Focus Groups." They include:

Jan Englert, RN, CCRN, North Mississippi Medical Center, Tupelo, "Removing QI Barriers One by One"

Georgia Millendar, RN, BSN, CPHQ, Baptist Memorial-Golden Triangle, Columbus, "Gadgets and Games: Making Quality Fun"

Marty Stuart, RN, Forrest General Hospital, Hattiesburg, "Quest for Excellence"

Other subjects for discussion during the two-day Forum will include discussion of the new hospitalist position, the legal issues in physician office compliance, Y2K and the physician's office, and the HCFA Sixth Scope of Work.

We are looking forward to strong physician support in this two-day Forum. For further information on times and specific programs or to obtain a registration form, call the I.Q.H. office.

—James S. McIlwain, M.D.,

*President and Principal Clinical Coordinator*

*The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Dept. Of Health and Human Services. The content does not necessarily reflect the view or policies of the Dept. Of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of ideas presented. The article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this contractor. Ideas and contributions concerning experience in engaging with issues presented are welcomed.*



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# University of Mississippi Medical Center

## Match Day Strikes First Picks for Most-Including Harvard

On Match Day at the UMC School of Medicine, 84 percent of the graduating seniors got their number one choice for a residency program - far better than the national average of 57 percent.

Forty-six of the 93 seniors chose to stay at UMC for that postgraduate training. UMC chose them, too, which makes a "match." The other 47 seniors were matched in medical centers across the country, in 18 other states, as the pairings were announced during March 18 ceremonies in Jackson.

Four of the students were matched with the Mayo Clinics - three in Rochester, Minn., and one in Jacksonville, Fla. - in internal medicine, dermatology, pathology and surgery-preliminary. Two will go to the University of Virginia at Charlottesville. Two more are destined for Duke University Medical Center in Durham, North Carolina. Wake Forest also wooed seven to University Baptist Medical Center in Durham, North Carolina.

Others discovered they were bound for Baylor College of Medicine in Houston, Tex.; the U.S. Naval Hospital in Portsmouth, Va.; Vanderbilt University Medical Center in Nashville, Tenn.; or Emory University School of Medicine in Atlanta.

But only one matched with Harvard University - Pearce McCarty III of Tupelo. It was McCarty's No. 1 choice on his rank list. McCarty will begin his residency in orthopedic surgery on July 1 at the Harvard Medical School Combined Program in Boston. Academically, he's currently third in his UMC class. Harvard accepted only nine students into its orthopedic surgery residency program this year.

"I couldn't have asked for anything more," said McCarty, 29, just after learning his match. He smiled quickly when he read the match letter on stage - and his face turned flush. It stayed flush through the rest of the ceremonies.

"Yes, he gets all red in the face when he's excited," said his fiancée, Lisa Hulst, who he'll marry on June 5.

"He's been very calm and collected today. But there's been some stress in the past few weeks."

March 18 officially is Match Day for medical residencies nationwide.

Dr. Helen R. Turner, associate dean for academic affairs for the School of Medicine, said of McCarty, "He's an extremely bright person, very articulate. We've enjoyed working with him.

"He's always been such an intense guy," she added. "His motivation has stood out in the class."

After graduating with honors from Tupelo High School in 1988, McCarty spent the next year in France as a Rotary Club International exchange student. He returned to study at Brown University in Providence, R.I., where he was graduated magna cum laude and Phi Beta Kappa in 1993, majoring in English and American literature. He worked at a research lab at Brown for one and one-half years after graduation, then came UMC to earn his medical degree.

He said he is "not at all" apprehensive about competing at Harvard - with some of the best medical minds in the world.

He credits UMC for putting him in that position.

"UMC has one of the best orthopedic surgery programs in the Southeast," McCarty said. "I could not have done what I've done without the help of (Department of Orthopedics Chairman) Dr. (James) Hughes and the rest of the faculty. Special thanks to them, for being my mentors. There are national and internationally known professors here."

Beyond that, McCarty said little after learning that Harvard had chosen him, too. "I'm probably not going to hear a word you say for the next half hour or so," he warned. As he left the match ceremonies, McCarty said, "I feel great. It will continue to sink in for the next few years . . . I mean the next few days."

Where are you, Cloud 9? "That's it," he grinned.

—Leslie R. Myers

**American Medical Association  
Organized Medical Staff Section (AMA-OMSS)**

*invites your medical staff to be represented at the*

**1999 Annual Assembly Meeting, June 17-21, in Chicago**

***Vision  
Voice  
Victory***



*If physicians want to be effective agents for change in improving today's health care, they need a vision, a voice, and a victory.*

The AMA-OMSS looks to medical staffs across the country for a **vision**. This vision gets a **voice** at the AMA-OMSS Assembly Meeting. This voice carries to the AMA House of Delegates, is amplified and acted on to score a **victory** at the national, state and/or local level. This victory may be new legislation, health care policy reform, improved quality standards, or the creation of resources to help physicians and their patients at home.

Be part of the process. Send a representative\* from your medical staff to the **1999 Annual AMA-OMSS Assembly Meeting, June 17-21, in Chicago**. *There is no fee to attend.*

OMSS representatives can:

- Submit resolutions prior to the Assembly meeting.
- Testify at Reference Committee hearings and vote in the Assembly.
- Participate in special issues forums.
- Network at state and regional caucuses.
- Earn up to 9 hours of CME credit\*\* (*Topics include: physician compensation, coping with stress, the computerized patient record, credentialing for new procedures, influencing physician behavior through quality improvement and cost containment efforts, medical staff development plans, physician-patient dynamics, and federal and state government action.*)

For more information on how to register, call **800 626-3211** and ask for the Department of Organized Medical Staff Services or e-mail us at [omss@ama-assn.org](mailto:omss@ama-assn.org).

\* Must be an AMA member

\*\* The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The American Medical Association designates this educational activity for up to 9 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

**American Medical Association**  
Physicians dedicated to the health of America



## New Members

**ANGEL, NICOLE LEE,** Pascagoula. Born Morgan City, LA, March 3, 1967; MD Louisiana State University School of Medicine, New Orleans, LA, 1993; internal medicine residency and oncology fellowship, Charity Hospital & University Hospital, New Orleans, LA, 1993-98; elected by Singing River Medical Society.

**HUNTER, GREGG S.,** Forest. Born Chattanooga, TN, Aug. 15, 1964; MD Meharry Medical College, Nashville, TN, 1991; psychiatry internship, same, 1992-93; psychiatry residency Howard University Hospital, Washington, DC, 1993-96; elected by Central Medical Society.

**JOHNSTON, L. DUBARD,** Madison. Born Nov. 17, 1968; MD

University of Mississippi School of Medicine, Jackson, MS, 1995; family practice residency, University Medical Center, Jackson, MS, 1995-96; elected by Central Medical Society.

**JONES, FREDERICK D.,** Oxford. Born Meridian, MS, Nov. 17, 1962; MD Howard University College of Medicine, Washington, DC, 1988; anesthesiology residency, University of Maryland, Baltimore, MD, 1993-96; critical care fellowship, same, 1996-97; elected by North MS Medical Society.

**LAYNE, SCOTT C.,** Jackson. Born Baton Rouge, LA, Oct. 10, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; internal medicine residency,

University Medical Center, Jackson, MS, 1995-98; elected by Central Medical Society.

**MINES, MARK H.,** Tupelo. Born Louisville, KY, April 6, 1962; MD University of Florida School of Medicine, Gainesville, FL, 1989; internal medicine residency, same, 1989-92; cardiology & interventional cardiology fellowships, same, 1992-96; elected by Northeast MS Medical Society.

**NATIONS, ROBIN D.,** Brookhaven. Born Jackson, MS, July 12, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family medicine internship, same; anesthesiology residency, same, 1993-96; elected by South Central Medical

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Society.

**NOYES, ERICA L.**, Corinth. Born Springfield, MO, January 1, 1970; MD University of Missouri School of Medicine, Columbia, MO, 1995; family medicine residency, St Johns Hospital, St. Louis, MO, 1995-98; elected by Northeast MS Medical Society.

**NOYES, TIMOTHY L.**, Corinth. Born Bellflower, CA, Dec. 22, 1969; MD University of Missouri School of Medicine, Columbia, MO, 1995; internal medicine residency, St Johns Hospital, St. Louis, MO, 1995-98; elected by Northeast MS Medical Society.

**ONEDERA, HELEN L.**, Jackson. Born Agana, Guam, June 19, 1966; MD East Tennessee State University College of Medicine, Johnson City, TN, 1994; interned one year, same; anesthesiology residency, University Medical Center, Jackson, MS, 1995-98; elected by Central Medical Society.

**PAPPAS, JOHN F.**, Gulfport. Born Maine, Oct. 19, 1963; MD Brown University School of Medicine, Providence, RI, 1990; ob-gyn residency, Hartford Hospital, Hartford, CT, 1991-94; elected by Coast Counties Medical Society.

**PLUNKETT, KAREN A.**, Greenwood. Born Greenwood, MS, Nov. 11, 1954; MD University of Mississippi School of Medicine, Jackson, MS, 1993; interned one year in medicine and neurology residency, University Medical Center, Jackson, MS, 1993-97; elected by Delta Medical Society.

**QUESNEL, GEORGES**, Batesville. Born Montreal, Canada, Feb. 12, 1940; MD University of Montreal School of Medicine, Montreal, Canada, 1965; ob-gyn residency, Laval University Medical Center, Quebec, Canada, 1969-73; elected by North MS Medical Society.

**REEVES-DARBY, VONDA GAIL**, Jackson. Born Collins, MS, Sept. 19, 1958; MD Meharry Medical College of Medicine, Nashville, TN, 1982; internal medicine residency, University of Texas Medical Branch, Galveston, TX, 1982-85; gastroenterology fellowship same; elected by Central Medical Society.

**STORY, CLIFTON W.**, Madison. Born April 4, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; family practice residency, same, 1995-98; elected by Central Medical Society.

**TWENTE, GEORGE E., II**, Meridian. Born Augusta, GA, Sept. 14, 1945; MD University of Mississippi School of Medicine, Jackson, MS, 1971; psychiatry residency, University of Florida Medical Center, Gainesville, FL, 1971-74; elected by East MS Medical Society.

## MSMA 131th Annual Session May 14-16, 1999

**Grand Resort  
Biloxi, Mississippi  
1-800-354-2450**

# Placement / Classified Service

**Journal MSMA Placement ads** are \$2.50/line, with a 5-line minimum charge of \$12.50. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing. Items should be sent to: **Placement Service, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229, or Fax to: 601/352-4834**

**Journal MSMA Display Classified ads** 1x insertion cost \$115.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge. Items should be sent to: **Classified Section, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229, or Fax to: 601/352-4834**

## PHYSICIANS NEEDED

Physicians (especially specialists such as cardiologists, ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office.

WATS 1-800-962-2230  
Jackson, 853-5487  
Leola Meyer (Ext.5487)



**Disability Determination Services**  
**1-800-962-2230**

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- The physician should delegate only those tasks which are within the scope of practice of the non-physician as defined by professional license and state law.
- The physician must be immediately available at all times whether in person, by telephone or other electronic means for consultation when needed by the non-physician. Appropriate arrangements must be made with another physician to cover when the first-line physician is not available. The back-up physician is responsible for the quality of medical care rendered in the absence of the primary physician to oversee care. Consistent with federal guidelines for rural health clinics, the covering physician must also be familiar with the parameters of the protocol and be evidenced by his/her signature on the document.
- The physician should use the protocol to address care of the patient after normal office hours. Arrangements should be made for patient referral to an appropriate, defined mechanism of after hours care.
- Clear transportation and back-up procedures should be established for the immediate care of patients needing emergency care or care beyond the scope of the non-physician.
- The physician is responsible for telling his/her patient that care is being deferred to an ancillary provider and the protocol should address notifying patients of the circumstances under which the physician will be consulted. Patients should be advised that the physician is ultimately responsible for decisions regarding care and the overall treatment plan.
- The physician should initiate and implement quality control mechanisms to insure that medical and surgical conditions are appropriately evaluated and treated. The quality control program should address continuing medical education for physicians in the management of team care arrangements.
- The physicians should review the quality of medical services rendered by the non-physician by regularly reviewing medical records to ensure compliance with directions and standards of care. Supervision from a site other than that of the non-physician should not hinder the physician's review of the quality of services provided. Protocols should address regular chart review, the frequency and extent of record review and a method so that the physician personally reviews each care in which the physician was consulted and issued orders without actually seeing the patient.
- The physician must afford supervision adequate to ensure that the non-physician provides care in accordance with accepted medical standards. (Physician supervision means that the non-physician only performs medical acts and procedures that have been specifically authorized and directed by the supervising physician.) The supervising physician bears both the authority and responsibility for the delegated acts.
- The protocol should address the actions that may be undertaken by the non-physician in all commonly encountered clinical situations and under what circumstances physician consultation is to be immediately obtained.
- The physician's decision to enter into a collaborative agreement with a non-physician should be solely that of the physician and not the result of a requirement imposed by a third party payor.
- Physicians should not enter into third-party protocols. (Example: A physician should not supervise a nurse practitioners who maintains a "disease management" protocol with a pharmacist.)

#### **Physician / Nurse Practitioner**

- The physician should require an initial period during which the nurse practitioner works on site under the

close supervision of the physician.

- Primary and back-up physicians should limit supervision of nurse practitioners practicing in a free-standing clinic to a number that can be properly managed.
- The physician should practice on site with a nurse practitioner a minimum of four (4) hours for every forty (40) hours of nurse practice time. The physician should review a minimum of 20 percent of the patient charts of those patients treated by the nurse practitioner.

#### **Physician / Pharmacist**

- Due to the precedent being set in Mississippi by physician/pharmacist protocols, the SBML should approve all physician/pharmacist protocols.
- The initial assessment of a patient for disease management is the responsibility of the treating physician. Only the patient's personal physician should refer a patient to a non-physician for monitoring and/or medication education or maintenance.
- Physicians should retain the responsibility to exercise independent medical judgement to select the drug of choice in disease management protocols.
- As the recommended period of on-site supervision will not likely be workable in a community setting, safeguards should be implemented so the physician can be familiar with the decision-making skills and assured that protocols adequately address tasks delegated to the pharmacist, mechanisms for site review and chart review.
- The physician should limit the number of patients referred to a pharmacist for disease monitoring and/or medication education and adjustment to a number that can be realistically managed.
- The physician who chooses to supervise both nurse practitioners and pharmacists via protocol must ensure that sufficient time and resources are available to oversee total patient care and adequately supervise the non-physicians.
- Physicians delegating a patient's medication management and/or education to a pharmacist should:
  - A. include mechanisms to maintain patient confidentiality and address the means by which patient information will be exchanged between pharmacist and physician.
  - B. initiate an individual protocol for each patient on a per drug basis in the community setting.
  - C. specifically address what type of laboratory tests indicate a change in medication dosage in each protocol.
  - D. ensure that mechanisms are included in each protocol so that the physician is efficiently notified of changes in dosing initiated by the non-physician.
  - E. be cognizant of the financial incentives for a pharmacist adjusting dosage via a protocol to take the patient to a higher dosage level or suggest a therapeutic substitution of a more lucrative or higher index drug.
  - F. avoid any effort to initiate a protocol exclusively for financial gain.

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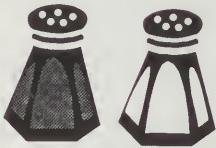
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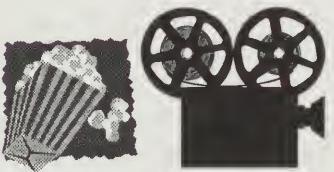
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# JOURNAL

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JUNE

1999

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Governing Council of the AMA Young Physicians Section

The Confederate Hospital at Beauvoir: A Dream for Restoration



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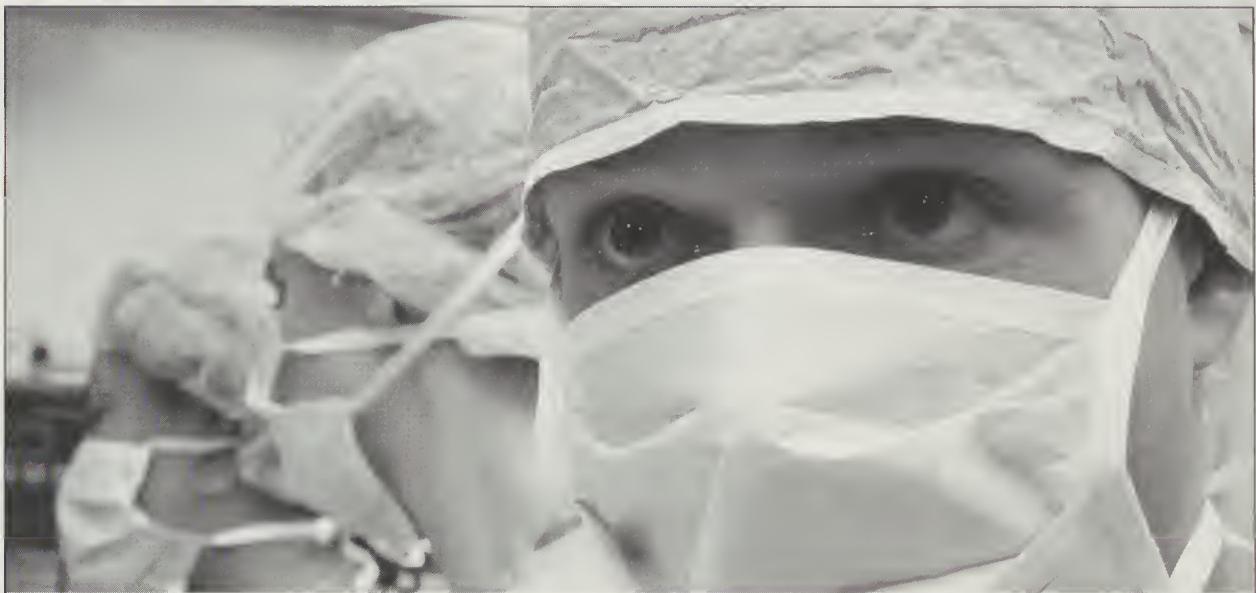
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**Cover photo:** As the Chief Flight Surgeon for the 186th Air Refueling Wing of the Mississippi Air National Guard in Meridian, John J. McGraw, M.D. is fond of taking photographs of airplanes in various settings, such as from KC 135's on Air Refueling Missions. Here, he found the sun setting on one of our own Mississippi Air National Guard planes upon one of his recent deployments to the Gulfport Reserve Training Center. A series of very severe thunderstorms which caused some local damage and flooding was well on its way to clearing when the sunset occurred. Dr. McGraw is an orthopedic surgeon with Laurel Bone & Joint Clinic, P.A.

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CASE RECORDS OF THE  
DEPARTMENT OF MEDICINE  
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CLINICOPATHOLOGIC CONFERENCE XXII

**Selection and Preparation:**

Michael W. Monson, M.D.

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Tammy H. Young, M.D.

Joe C. Files, M.D., *Editor*

**Differential Findings:** Anastasios A. Mihas, M.D.

**Radiological Findings:** R. Kevin Cole, M.D.

**Pathological Findings:** Michael D. Hughson, M.D.

CASE PRESENTATION

Today's case concerns a 53 year old man with no significant past medical history who presented to the hospital with a 3 week history of fatigue, malaise, and increasing abdominal girth. Physical examination revealed bilateral crackles and dullness on percussion, as well as tense ascites. Pertinent lab abnormalities included leukocytosis with extreme left shift, hyperglycemia, and an abnormal renal panel. Interestingly enough, all liver tests were within the normal range except for a low albumin. In spite of several diagnostic tests and procedures, he died before a diagnosis could be reached.

**Dr. Mihas:** Ascites has been tantalizing physicians and laymen alike since antiquity. It was first described by Hippocrates, and according to Celsus, the first abdominal paracentesis was done 2,000 years ago. Ludwig van Beethoven was the most famous person to undergo large volume paracentesis. According to the story, toward the end of his life, Beethoven called his family physician because he had developed tense ascites and could not breathe. He was begging him "to do something" about it. His doctor performed the abdominal tap and fluid started flowing out of his belly. Beethoven then broke into tears of joy and started screaming "What a relief!". He died two days later, most likely from bacterial peritonitis, another victim of iatrogenic generosity. Thus, at his death, the greatest composer of all reversed himself: He first sang the *ode to joy* of his ninth symphony and then the *Eroice!*. An autopsy that was performed disclosed advanced liver cirrhosis.

I have a couple of questions for Dr. Cole regarding the interpretation of the radiological studies: First of all,

was the caudate lobe of the liver enlarged? From the angle I saw the CT, I did not see such an enlargement. Second, how do you account for the high IVC and FHVP pressures? I must agree that the Hepatic Venous Pressure Gradient (HVPG) was only 6mm HG, which is normal. The third question concerns the patency of the hepatic veins: Were the hepatic veins opacified with contrast material or was there any difficulty in their catheterization?

When I first glanced at the case and read the very first lines, I thought about the fact that the patient had a father with emphysema, a grandfather with cirrhosis, a sister with liver disease, and now the patient himself presents with ascites. The chief resident just wanted to give me some hints about the diagnosis of  $A_1$ -antitrypsin deficiency. But the more I read, the more complicated and confusing the story got. I believe that in these mental exercises, and I do not say this as an excuse, it is not as important to give the exact histological diagnosis but to depict the rational approach to the problem and teach techniques that will enhance our skills for detecting treatable disease. As for missing the correct diagnosis, I can assure you that it will not hurt my ego. I have been wrong before!

**Dr. Cole:** The radiograph shows diffuse opacities in the lung bases with blunting and fluid in the minor fissure on the right. We thought this was consistent with bilateral pleural effusions and possibly some atelectasis or infiltrate in his bases. This radiograph was taken later in the hospital course and demonstrated worsening on the right side consistent with worsening pleural effusions and atelectasis. The left side was unchanged. These were ultrasound images that were done during his hospital course. The kidneys demonstrated normal echogenicity and normal size. We didn't really see anything abnormal with the kidneys. There is an area of low echogenicity adjacent to the liver and we thought that this was consistent with ascites which we knew the patient had. We also have some images of the spleen along with splenic measurements which were enlarged. However, the splenic blood flow was in the normal direction. The patient then had a CT of the abdomen and pelvis done and these images demonstrated bilateral effusions, larger on the right with some atelectasis in the bases. As we move down into the pelvis, the images demonstrate ascites and hepatosplenomegaly. A little further down in the pelvis, we again see ascites along the boundary of the omentum. The fluid has a more increased density than would normally be seen for a benign type of ascites. We thought that there may be omental thickening or that this was at least not a benign

picture of ascites. A couple of days later, the patient had a CT scan of the chest. The largest lymph node measured 3 x 2cms. Lower in the chest, there are areas of low density we thought were enlarged nodes consistent with mediastinal adenopathy. A little further down on the images of the chest there are several low density areas around the pericardium consistent with pericardial lymph nodes. We were then asked to attempt a biopsy of his peritoneum to see if we could get any tissue that might help out with the diagnosis. We did several other interventional procedures including several CT guided therapeutic paracenteses. A transjugular hepatic venogram was performed that was essentially unremarkable.

**Dr. Mihas:** Before I proceed with the differential diagnosis of this case, I would like to briefly review some basics about the formation, composition, presentation, and work up of ascites. The word ascites derives from the Greek term "askos", which means bag or sac. It is the accumulation of fluid in the area between the organs in the intra-abdominal cavity and is always abnormal. It is very important to note that there are no normal values for ascitic constituents. Of course, a small amount of peritoneal fluid (< 25ml) is present, which allows for lubrication as the intestines move in response to the passage of food.

In a slide of this patient, it is obvious that cirrhosis of the liver dominates the picture. More than 80% of patients with ascites are found to have liver cirrhosis. From the remainder, roughly half the cases are caused by some type of malignancy and the rest by other causes whose contribution does not exceed 1%, perhaps with the exception of tuberculosis.

How is normal peritoneal fluid produced? Peritoneal fluid arises from the filtration of fluid from the intravascular compartment to the interstitial space of organs within the peritoneal cavity and subsequent passage across the intact peritoneal membrane into the peritoneal cavity. This filtration of fluid is driven by hydrostatic gradients across biological membranes and does not require active transport. The fluid entering the peritoneal cavity is drained by the diaphragm since the direction of all hydrostatic gradients that determine the fluid movements are into the peritoneal cavity except at the diaphragm. Thus, net peritoneal fluid moves out of the peritoneal cavity at the diaphragm. The lymph of all intra-abdominal organs, including the liver, gut, spleen, pancreas, etc., is drained via the left thoracic duct back into the vascular compartment. The exception is the diaphragm, draining the peritoneal fluid, and the right pleural space and right lung which are drained by the right thoracic duct system, which has a much lower capacity than the left thoracic duct

system. This inefficiency has some important clinicopathologic implications.

It is known that biological membranes separating vascular and extra-vascular compartments are semi-permeable to proteins but the degree of permeability differs widely among the different organs. For example, the permeability of systemic capillary, pulmonary capillary, and peritoneum have the lowest permeability. By contrast, intestinal capillary is 200 times more permeable and sinusoids have a 1000-fold increase in permeability compared to systemic capillary. These figures set the tone and give you some indications about the potential sites of formation of ascites. Thus, the highly permeable intestinal capillary produces filtered fluid that is absorbed via lymphatics. The fluid production, however, is minimal because of the low capillary hydrostatic pressure due to the low portal vein pressure (- 6mm Hg). By contrast, in pathological states, accumulation of fluid will occur. The respective liver capillary is the sinusoid. The endothelial cell in the hepatic sinusoid has a fenestrated membrane that allows rapid access of plasma to the interstitial space of the liver, i.e. the space of Disse. Thus, the capillary membrane of the liver is very permeable and the rate of fluid entering this space is directly related to the portal pressure gradient, which is normally low, i.e. < 6mm Hg. Hepatic congestion due to post- or sinusoidal portal hypertension markedly elevates the gradient for filtration of plasma and increased lymph flow in the space of Disse. By contrast, presinusoidal portal hypertension does not cause hepatic congestion and does not cause ascites. Typical example is Schistosomiasis, where, in spite of tremendous portal pressures, there is no ascites. In the normal state, the rate of fluid absorption across the diaphragm usually exceeds the rate of peritoneal fluid formation. Thus, one can figure out that ascites results whenever there is an imbalance in the system and peritoneal fluid formation exceeds absorption.

Pleural effusion in patients with cirrhosis is always on the right side and minimal on the left side, as it was in this case. Like ascites, it is multifactorial and includes: 1) the decrease in plasma colloid osmotic pressure that increases pleural fluid formation, 2) limited drainage of the right pleural space (low capacity system), and 3) competition with ascites. A more significant type of right pleural fluid accumulation producing massive right hydrothorax is due to the so-called "Liebermann's holes" and is associated with ascites, but may also occur without ascites. These holes are small perforations through the diaphragm at the sites where the pleural and peritoneal membrane are closely associated. These holes appear to be formed as this close approximation of membranes

rupture in response to tense ascites. Occasionally, there can even be huge rents in the diaphragm. The typical history is that of tense ascites followed by sudden onset of shortness of breath and decrease in the ascites as it enters the chest. I have seen repeated thoracentesis done for the evacuation of the pleural fluid and even placement of a chest tube. Both modalities are futile as fluid will continue to flow from the peritoneal into the chest cavity. It is so much easier to do a large volume abdominal paracentesis and implement vigorous diuretic therapy.

I have discussed the causes of ascites, but how can one classify ascites according to its pathogenesis? This is done according to whether or not the ascites is due to portal hypertension, which is *portal hypertensive* and is responsible for 90% of the cases, and *non-portal hypertensive*. There is also a very small percentage of mixed ascites. Although most of the exciting and complicated pathophysiological mechanisms of ascites are related to the portal hypertensive variety, intra-abdominal malignancy and peritoneal carcinomatosis constitute an interesting entity. In these patients, ascites results from a combination of increased formation from blockage of intestinal lymphatics and decreased absorption from the diaphragm. In addition, half the patients may have secretion of cytokines or tumor related products that increase peritoneal membrane permeability.

Other causes of non-portal hypertensive ascites are usually due to the rupture and/or leak of a particular intra-abdominal viscus. As I mentioned earlier, ascites comes from the Greek word "askos", which means sac or bag. But, it is actually synonymous with paracentesis. Every single time you encounter a patient with new onset ascites or you admit to the hospital a patient with long-standing ascites, there is no excuse not to draw at least 50cc for diagnostic purposes. The diagnostic tests fall into three different categories: mandatory, optional, and unusual. It is obvious that the most important tests are the WBC count, the albumin content, and fluid culture. Can ascitic fluid be classified either as a transudate or an exudate on the basis of these tests? In older medical textbooks, ascites was classified according to its protein content with the cut off point set at 2.5 or 3g/dL. In recent years, it has been shown that this method was not accurate and was misclassifying several cases. For example, CHF-related ascites is a transudate with high protein content. In the early 90s, Bruce Runyon, a leader in this field, showed that the simultaneous measurement of the albumin concentration in the ascites and in the serum was far more accurate in identifying the cases associated with portal hypertension and separating them from those without.

What is SAAG? This acronym stands for the

gradient between the serum and the ascitic fluid albumin concentration. Did this patient have portal hypertensive ascites? According to his SAAG, he did not. But, keep in mind that like every test in medicine, SAAG also has its limitations. First, it does not cover 100% of the cases, and second, execution of the test must be perfect. I mentioned earlier that paracentesis is mandatory in every case of ascites and there are no contraindications. From 1,000 consecutive paracenteses, Runyon reported very low complication rates. The next question relates to whether the patient has SBP. With a PMN count of over 3,000 cells per mm<sup>3</sup> in the ascitic fluid, this is unequivocal SBP and very correctly the attending physicians proceeded with its treatment. I know that there was a history of prior use of diuretics and I was asked to also address this issue along with possible changes in protein concentration caused by diuretics. There are good data on this. It is true that due to concentration, both WBC and protein contents go up. However, as far as protein is concerned, the SAAG does not change. Likewise, WBC goes up but the PMN number remains constant for as long as chemotaxis continues to be present.

Let us move to the differential diagnosis of this case. I feel comfortable to rule out congenital etiology and the Meig's syndrome on the basis of age and gender. The next diagnosis is a very important one. Did this man have cirrhosis of the liver? If you are a gambler, you may want to go with the odds, and I just said that over 80% of cases of ascites are due to cirrhosis. But in CPCs, you've got to consider the unusual and the exceptions. What is the evidence of cirrhosis in this case?

1. There is no prior history of liver disease, no serological markers for viral hepatitis B or C, and all liver tests were normal, although cryptogenic liver disease may present exactly like that.

2. The SAAG was less than 1.1, which is against portal hypertensive ascites. In fact, the HVPG, which was only 6mm Hg, provides undisputed evidence against sinusoidal portal hypertension, which is the mechanism of cirrhotic ascites.

3. A liver biopsy was negative for cirrhosis. Although "sampling error" could account for a false negative result, in this case the pathologist had the opportunity to examine enough tissue and, more importantly, at least 15 portal areas. Statistically, the magic number is 9 to confidently rule out cirrhosis. Thus, it seems that I have no choice but to eliminate this diagnosis.

Was the ascites the result of tuberculosis? Tuberculous ascites should always be considered in the differential diagnosis but not in this case. There is no history of

chronic fever, night sweats, profound wasting, or abdominal pain. Usually, patients with TB peritonitis are extremely sick. But, how reliable are the TB tests such as AFB stains and TB culture? The respective percentages are 25-30% and 50-70%. Peritoneoscopic biopsies increase these numbers to 90%. Next on the list is pancreatic ascites. Pancreatic ascites is the result of either acute or chronic pancreatitis with rupture of the pancreatic duct. It is a protein-rich fluid and the amylase is in the thousands. In our case it was only 30!

The next possibility is constrictive pericarditis, which is one of the most under diagnosed causes of ascites. However, the pericardial effusion reported was minimal and there was no evidence of constriction or JVD. Moreover, I have already established that according to the SAAG, the ascitic fluid was an exudate. Last but not least, the liver biopsy was not suggestive of this diagnosis. There is nothing to suggest Budd-Chiari syndrome. The classical clinical triad of abdominal pain, ascites, and hepatomegaly was absent and there are no overt risk factors. Hepatic catheterization was successful, the caudate lobe of the liver was not enlarged, and the characteristic liver biopsy for this entity is lacking.

Nephrotic ascites is extremely rare in adults and we do not have any evidence to support this diagnosis in our case. Nephrogenous or Nephrogenic ascites is a peculiar entity that develops in patients with renal failure who are on hemodialysis. Its etiology is usually multifactorial and includes among others, a "leaky" peritoneum, chronic fluid overload, and impaired lymphatic removal of peritoneal fluid. Likewise, there is not a shred of evidence for either myxedematous or chylous ascites. After all, the triglyceride level in the ascitic fluid was only 30mg/dL. In cases of chylous ascites, it is usually near 1,000.

This was a man who had a rather fulminant illness and died within 3 weeks from the onset of his symptoms. A malignant neoplasm would do that. We also heard that there was an omental mass by CT. Another interesting finding was the elevated LDH values in both serum and ascites. Therefore, the probability of a malignant lesion becomes very appealing. Malignancy, but of what kind? When I reviewed the literature, I came across several cases from the CPCs at MGM. Nearly all the cases included one of the following neoplasms: Hepatoma, mesothelioma, and lymphoproliferative disease. In our case, hepatoma seems to be unlikely because there is no evidence of liver cirrhosis, not even HBV-positive serology, and the CT is negative for malignant neoplasms of the liver. Moreover, approximately 50% of the ascitic fluids in hepatoma are bloody.

Although mesothelioma can form a large mass, it

usually is diffuse on the peritoneum. In our case, there is no prior history of pleural mesothelioma nor prior exposure to asbestos. However, in a larger study from MGM of 100 cases of mesothelioma limited to the peritoneal cavity, only 2/3 of the patients had such a history. Also, the fluid is frequently bloody.

It seems that at this juncture, I cannot change my mind and I find myself with the diagnosis of peritoneal carcinomatosis. Whether this was due to an intra-abdominal carcinoma with widespread peritoneal metastases or to a lymphoproliferative disease, I leave it to the pathologist to tell us. I should point out, however, that the absence of a primary solid tumor, the high ascitic fluid LDH, and the fulminant course speak in favor of a lymphoproliferative process.

**Dr. Hughson:** The autopsy demonstrated over 3,000cc of serous fluid within the abdominal cavity. In addition, the omentum and small intestinal mesentery were filled with tumor which coated the serosal surfaces of the intestines producing multiple peritoneal adhesions. Fleshy white tumor massively enlarged the periaortic and peripancreatic lymph nodes and lymph nodes at the hilum of the liver and spleen. The liver and spleen were enlarged, the liver at 3925 grams (normal being 1500 grams) and the spleen at 850 grams (normal being 150 grams). The capsular surface of the liver was smooth, and the sectioned surface showed a normal appearing parenchyma without evidence of cirrhosis. The spleen contained no discreet masses.

Histologically, the omentum, mesentery, and abdominal lymph nodes were infiltrated by a malignant lymphoma composed predominantly of small, round, well-differentiated lymphocytes. Interspersed among the small lymphocytes were large atypical cells. Immunohistochemical stains identified the small cells as T-lymphocytes (UCHL-1 positive, and L-26 negative). The large cells did not stain with either antibody and could not be immunohistochemically identified as either B- or T-cells. The lymphoma was found in the portal areas and sinusoids of the liver, and diffusely throughout the red pulp of the spleen. Lymphoma infiltrated the walls of the small and large intestines and stomach, the heart, and pericolic and retroperitoneal adipose tissue outside of lymph nodes. Tumor also infiltrated the epicardium and the outer layers of the myocardium. Lymphomatous nodules were found in the lung surrounding small bronchi and infiltrating the pleura.

This lymphoma presents the diagnostic problem of a polymorphous low-grade lymphoma composed predominantly of small, well-differentiated lymphocytes. The

differential diagnoses include small lymphocytic lymphoma, T-cell rich B-cell lymphoma, and lymphomatoid granulomatosis. Small lymphocytic lymphoma overlaps in its clinical manifestation with chronic lymphocytic leukemia (CLL) and Waldenstrom's macroglobulinemia. In these disorders, and in 97% of small lymphocytic lymphomas, the small lymphocytes will mark as B-lymphocytes. An examination of a serum protein electrophoresis showed no M-protein, and specifically no elevation of IgM. In a T-cell rich B-cell lymphoma, the large cells can be identified as B-cells, which was not the case in this patient's tumor. Lymphomatoid granulomatosis (LYG) is primarily a disease of the lungs and upper respiratory tract. It can be composed of a predominance of small, well-differentiated T-cells and can also involve extrapulmonary sites such as the gastrointestinal tract. LYG has been grouped with other polymorphous lymphomas composed mainly of small T-cells as angiocentric immunoproliferative lesions. In the lung in this patient, an angiocentric pattern could occasionally be found, and in some retroperitoneal lymph nodes, vascular necrosis and lymph node infarction was seen. LYG may be the best diagnosis for this lymphoma, although it must be recognized that approximately 3% of small lymphocytic lymphomas are T-cell rather than B-cell neoplasm. In this case, we will not try to make a distinction between these two neoplasms, except to note that it was not associated with CLL as are many small lymphocytic lymphomas.

#### **Pathologic diagnosis:**

- 1) Malignant lymphoma, low-grade, polymorphic. T-cell small lymphocytic lymphoma versus lymphomatoid granulomatosis, involving intestines, mesentery, omentum, retroperitoneal lymph nodes, lung, heart, liver, and spleen.
- 2) Malignant ascites.

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**Dr. Files is Professor of Medicine and Associate Chairman, Department of Medicine.**

**Dr. Mihas is Professor of Medicine.**

**Dr. Cole is a resident in the Department of Pathology.**

**Dr. Hughson is Director, Department of Pathology.**

**Drs. Monson, Warnock, and Young are Chief Medicine Residents in the Department of Medicine at the University Medical Center, 1998-99.**

## **SINGING RIVER RADIOLOGY GROUP, PA PASCAGOULA, MISSISSIPPI**

**TAKES PLEASURE IN  
ANNOUNCING THE ASSOCIATION OF  
S. KATHERINE CARROLL, M.D.**

**AND  
DONNA L. DONATI, M.D.**

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WILLIAM R. EHLERT, M.D.  
HAL MOORE, M.D.  
ROLAND J. MESTAYER III, M.D.  
T. NEAL POLCHOW, M.D.**

# MisHIN: An Outreach Program to Help Practicing Physicians Keep Up with Medical Literature

**Ada M. Seltzer, MLS, MA, Director, Rowland Medical Library  
James P. Spell, M.D., Chair, Friends of the Library Endowment  
University of Mississippi Medical Center  
Jackson, MS**

**I**nformation in the medical field is exploding. There are 400,000 entries to the National Library of Medicine Medline database each year. A practitioner would have to read 6,000 articles a day to keep current with the burgeoning knowledge in the field of medicine.<sup>1</sup>

The Rowland Medical Library at the University of Mississippi Medical Center is the headquarters for a unique computer program which offers Internet access to medical information. It is called MisHIN (Mississippi Health Sciences Information Network). Members can perform literature searches and receive clinical information from a variety of databases. They can also receive photocopies of journal articles and textbook pages.

MisHIN members do not have to own computers to take advantage of the many information services offered by the network. All traditional library services are available at reduced rates to members with or without computers. Remote 800 dial access is available for members without computers.

There are approximately 13 health literature citation databases, including Medline, PubMed, CancerLit, and Evidence-Based Medicine. There are over 40 CD-ROM full text sources. There are also 30 general literature databases relative to business, finance, biology, life sciences, agriculture and environmental issues.

Membership in MisHIN is available to any physician or health-related organization. Monthly service rates

for individuals are \$15.00/month for Internet access through other service providers (AOL, Netdoor, etc.) and \$25.00/month for dial access to MisHIN which in turn provides Internet capabilities. Group rates are also available.

MisHIN electronic services require a minimum 90 Mhz Pentium computer with a SVGA monitor, 32 Mb RAM, Windows 95, 98 or NT operating system, a Web browser and at least a 28.8 baud modem for dial access. Better equipment gives faster service.

Several libraries and health agencies are participating in the MisHIN program. These collaborators are listed below.

### Libraries

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**Delta State University**

**Forrest General Hospital**

**Mississippi State University,  
College of Veterinary Medicine**

**Mississippi University for Women**

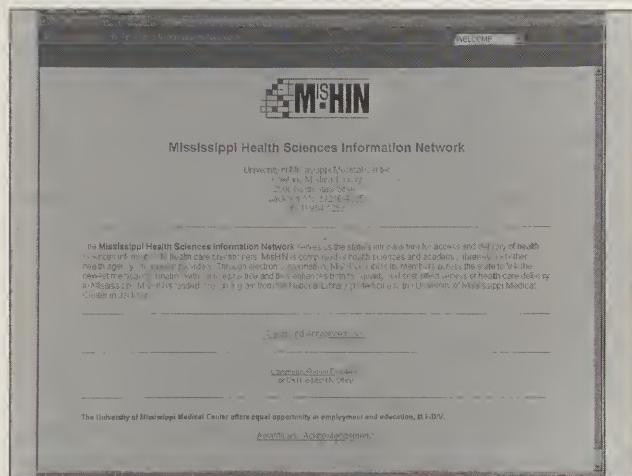


Fig 1.—MisHIN home page, <http://mishin.umsmed.edu> or use the link on the MSMA home page, <http://www.msmed.org>.



Fig 2.—MisHIN staff Cynthia Thompson and Amy Scoggins explain database searching to MisHIN member, Dr. James P. Spell.

## **University of Mississippi Medical Center, Rowland Medical Library**

### **VA/Gulf Coast Veterans Health Care System**

#### **HEALTH ORGANIZATIONS**

##### **Mississippi Nurses Association**

##### **Mississippi State Department of Health**

##### **Mississippi State Medical Association**

##### **University of Mississippi, Department of Clinical Pharmacy**

##### **University of Mississippi Medical Center, Department of Surgery**

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Fig 3.—Rissa Richardson, networking administrator, manages the computer systems for all MisHIN services.

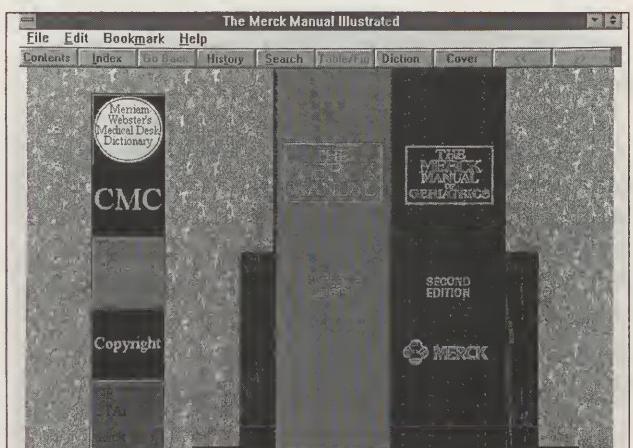


Fig 4.—Introductory screen for the full text database: Merck Manual Illustrated

## Coding Concepts

**Q. When is it appropriate to use the unlisted procedure codes? What supporting documentation is required?**

A. Unlisted codes should be used when you cannot find a description in **CPT or HCPCS** to accurately describe the service(s) provided to a patient. Since each section of CPT contains a listing of unlisted procedure codes, you will need to choose the code from that subsection or subheading. Processing unlisted codes takes longer since the services are usually sent to medical review for evaluation and payment consideration.

In documenting unlisted services, include a description of the procedure, medical necessity, a statement of time and effort required for the procedure, and comparisons with other existing codes. Be sure to attach a fee to your services to assist payers in developing reimbursement allocations.

For example, a physician developed a new surgical procedure through a laparoscope. CPT describes an incisional procedure only. According to AMA guidelines, it would be inappropriate to submit the service using the incisional procedure as it does not describe the actual service or consider the different risk factors involved. To correctly report the service, use the unlisted surgical laparoscopy code, 56398, and submit supporting documentation.

**Q. What ICD-9-CM code should be used for a patient on medication for recurrent seizures?**

A. In order to select the appropriate ICD-9-CM code, you **must** first determine the cause of the seizures. For example, recurrent seizures may be caused by epilepsy, central nervous system neoplasms, metabolic disorders, or toxic effects of drugs. In the Index under seizures, you will find the following categories:

Seizure

Recurrent - 780.39 epileptic - see Epilepsy

Repetitive - 780.39 epileptic - see Epilepsy

If the patient has epilepsy, use the appropriate code from that category. Otherwise, use Code 780.39 as it describes Convulsion NOS, Convulsive disorder NOS, or Seizure NOS.

**Q. Sometimes we have patients who have to be admitted to observation following ambulatory surgery for monitoring before they can be discharged. The resulting problem is finding a diagnosis to support the additional service. Should we use V codes? Any suggestions?**

A. In coding a diagnosis, you may only code to the highest degree of certainty established by the physician's documentation. Therefore, if the patient was admitted due to nausea, increase in blood pressure, fever, etc., it would be appropriate to use these as principle diagnoses. Symptoms necessitating observation should be coded and sequenced according to acuity.

If the documentation does not support a sign or symptom, you would need to use a V code as the diagnosis. Some applicable V codes are as follows:

V71 Observation and evaluation for suspect condition.

(Code to the highest level of specificity)

V67.0 Follow up exam after surgery

It should be noted that many carriers do not consider V codes as sufficient justification for admission to observation and will deny the service as medically unnecessary. Whenever possible based on the documentation, code the sign or symptom resulting in the patient being admitted to observation.

**Q. According to the Table of Drugs and Chemicals, should the therapeutic E codes be used with poisonings?**

A. The therapeutic use column was placed in the Table of Drugs and Chemicals as a means to save space. Otherwise, the table would have had to be reproduced for just that one column. These E codes identify the substance resulting in an **adverse effect** of a drug correctly administered. These codes should not be used with the codes to indicate a poisoning.

**Q. I am a new coder and get confused as how to define or place the various components of history. Are there any rules or guidelines to assist me with making an intelligent judgement call regarding the History of Present Illness (HPI) categories?**

A. While there are no official rules or guidelines to define the components of the HPI, I offer the following as a guide to assist you in categorizing the components.

• **Location:** The specific area of the body causing the problem. Not every history will state a location.

• **Quality:** Look for descriptions such as sharp, dull, throbbing, acute, chronic, intermittent, itching, scratching, etc.

• **Severity:** Describes the severity of the pain usually measured on a scale of 1 -10. Severity is considered a quality. You may see wording to the effect of: the patient feels well, patient became frightened or expressed deep concern, etc.

• **Duration:** How long from the onset of the problem until the patient sought treatment. You will typically see statements such as yesterday, five hours ago, last week, etc.

• **Timing:** Establishing the onset of the problem or to describe the regularity of the problem. Typical statements would be pain comes and goes, continuous, no relief, frequently, seldom, etc.

• **Context:** Generally describes how the complaint or condition occurred or coexists with activity. Look for statements such as sitting, running, playing, driving, going down steps, etc.

• **Modifying Factors:** Describes what did the patient do to make the problem better or worse. Typical statements would include: Took aspirin, soaked in a hot tub, slept in a chair, propped up the leg, used an ace bandage, etc.

**Associated signs or Symptoms:** Generally includes other problems, conditions, or symptoms the patient may be experiencing. The language not only describes the chief complaint, but it may also be defining an associated sign or symptom such as a patient who presents for a headache may also complain of blurred vision, a patient with a low grade fever complains of nausea and vomiting, or nasal congestion with ear ache.

**NOTE:** While a statement or description may often apply to more than one area of the HPI, it can only be counted in just one of the categories.

**Q. Currently, we are experiencing a difference of opinion in the office regarding when a patient should be considered new. Is a patient considered to be new when he or she presents with a new diagnosis? What about a patient seen in a location other than the office who then comes to the office?**

A. According to AMA and HCFA guidelines, a new patient is one who has not received professional services from the same physician or physician of the same specialty. This difference is not based on diagnosis, location of service, or a face-to-face visit. It is simply based on whether or not a physician or physician of the same specialty in your group has provided a professional service within a three-year period.

There are several key points in this statement that should be addressed.

1.) Provision of a professional service. This indicates a specific service guideline.

A patient was seen one time only in the office January 5, 1993. The physician refilled a prescription for this patient on April 2, 1993. The patient's next visit to the office occurred on January 6, 1996. How would you classify this visit - new or established? This is an example of "**provision of professional services.**" Since a professional service (refilling a prescription) was provided in April, this visit should be billed as an established patient level of service. The January '96 visit is within three years from the date of the "provision of a professional service" in April.

2.) The language "**same specialty**" is very important since physicians of different specialties are merging into single groups.

For example, a patient was seen by a family practice physician. The patient developed severe abdominal

pain. The family practitioner was unable to locate the cause of the problem. The patient was advised to see a partner in the group, a gastroenterologist. Although the physicians' group share staff, office space, charts, and a tax I.D. number, the patient could be classified as a new patient provided the gastroenterologist has not seen or provided a professional service to the patient within the three-year period.

**Q. Please advise correct billing for the following scenario. A patient was seen in the emergency department for abdominal pain. The physician who evaluated the patient determined the patient required surgery. What can be billed for this service? Would it be appropriate to bill an evaluation and management code with the surgical procedure?**

A. According to AMA and HCFA guidelines, an evaluation and management (E/M) service may be billed on the same day as a major service when the decision to do surgery is on that day or within a 24-hour period. According to HCFA guidelines, a major procedure is one with 90 days follow up. By AMA definition, a major service is one not classified as minor surgery. Modifier -57, Decision for Surgery, is the communication tool to indicate the actual date the decision was made to provide a surgical procedure.

According to HCFA guidelines, the first twenty-four hours prior to surgery are considered to be part of the global service. When the decision for surgery is within 24-hours of the surgery, the surgeon is entitled to bill for an E/M service since that is the time the decision was made to provide the surgery. Modifier -57 should be placed after the correct level of evaluation and management code.

For minor surgery, use Modifier -25, Separately identifiable service or procedure by the same physician on the day of a procedure or other service.

For HCFA, a minor procedure is one with zero to ten days follow up. According to AMA, a minor procedure is one identified by a star or asterisk.

#### CODING TIP OF THE MONTH

Modifiers provide a useful communication link with insurance companies. However when a carrier does not recognize a modifier, the result could be a delayed payment. When you have a contract agreement with an insurance company, find out how they view modifiers.

*Do you have a question you would like answered in this article? Please send your inquiries to Wanda L. Adams, CPC, 3280 Lupine Drive, Arnold, MO 63010.*

*Please include your name and phone number should additional information be required.*

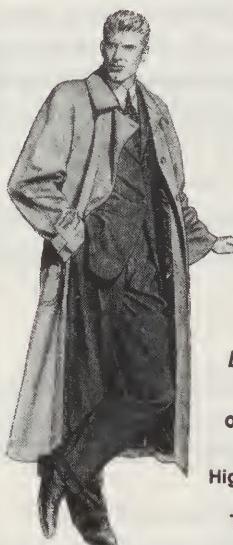
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Wanda L. Adams, CPC, is owner and president of Adams & Associates, a healthcare consulting firm. She is a senior health care consultant and published author. She currently serves on the National Advisory Board of the AAPC. Her article Coding Concepts appears in several medical business journals.

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**Michael H. Carter, Jr., M.D.**

**Valedictory Address  
14 May 1999  
MSMA House of Delegates  
131st Annual Session  
Biloxi, MS**

**G**ood morning. After a year working as your President, I can't tell you what a pleasure it is to be speaking to you, giving my valedictory remarks. This has been a strenuous year, but a wonderful year for me personally, and it has been a very good year for the Mississippi State Medical Association.

This upcoming year is the beginning of my disengagement from my fairly intense involvement with MSMA. It punctuates not only a year as President, but this will be my ninth, and last, year on the MSMA Board of Trustees. And it's been a very rewarding trip for me personally.

I am drawn to the image of life as a series of journeys. A favorite essayist of mine, Wendell Berry, describes a marriage in such terms. At the beginning of a marriage two people make a decision to be husband and wife, and they make a series of promises to each other and to the marriage itself, describing the principles of a marriage and agreeing together to certain terms. The couple then sets out together on life's journey. Many things---most things --- about this journey they don't know yet. They do know something about the end --because they've promised --- that it will end with the death of one of them. But they don't know which one---when --- or under what circumstances.

They don't know about the adventures, the good fortunes, the misfortunes they will encounter. They don't know whether they'll have a family, even, let alone how things will develop for their children. And they actually have no better idea about near-term things than about long-term matters.

But they do know that they will be taking this journey together. They've decided and promised this on the front end... and they know some of the fundamental terms of their relationship --- they've made willing and reciprocal promises.

Such is the nature of participation in our medical profession. The Hippocratic Oath describes some of the nature of this voyage. But beyond this, we soon become aware of important, defining traditions of this profession --- honesty ... mutual respect and consideration among physicians ... excellence in our work... the primacy of the patient's well-being in all our activities and efforts. And we work together to support these principles, which are implicit in our profession and which quickly become ingrained even in green medical students --- even in those such as I, who didn't come here in medical families.

Like a marriage, though, when we set out on the lifelong, parallel voyage in the medical profession, we don't know exactly where it will lead us. We enter various specialties, for various reasons ... We live and work in different, and different types of, communities and situations ... Extraneous forces and circumstances influence the courses of our careers ... We may be public health officers or neurosurgeons --medical missionaries or corporate executives or epidemiologists --- or any combination of these and more.

But wherever our various individual voyages take us, the same fundamental principles --- honesty, mutual respect and consideration among physicians, excellence in our work, and the primacy of the patient's well-being --- are shared principles, and all physicians subscribe to them.

We here today are a cut of physicians who share some more specific interests and agendas. I don't berate physicians who are uninclined to participate very actively in organized medicine --- some of my colleagues whom I respect and admire extremely cannot abide a meeting.

But I must say that you here today are a very special group of friends of mine. I have enjoyed participating with you in this medical organization. When I initially went on the Board of Trustees, my good friend Joe Burnett told me of the pleasure he had derived from "associating with some of the best doctors in Mississippi," and he wished the same for me. Well, his wish for me certainly came true.

I want to change directions for a minute, with a true story. Many of you know Dick Meek, who practices Ob/Gyn in Greenwood... Dick and I are lifelong friends. Well, a few years ago a fishing buddy of Dick's, a local florist who lives in his shop in a rather old residence in downtown Greenwood, had invited Dick over to eat bass one afternoon. While waiting for the fish dinner, Dick was wandering around the shop, looking around, when he spotted a remarkable floral arrangement: He described a large circular spray of flowers with, in its center, a princess telephone, and an inscription, "Jesus called." Dick hurried to ask his friend for explication about this unusual item, and the florist said that it was a very popular funeral arrangement, and that it was surprising how many people typically would walk over, pick up the receiver, and just listen. Dick asked if the arrangement was the florist's original idea, to which he replied, "No, I didn't invent this arrangement, but I am proud to have brought it to its present state of perfection."

Well, I didn't invent the Mississippi State Medical Association, and I can claim much less credit for its success than that florist did for those flowers, but I am happy nevertheless to report to you that MSMA is in excellent working condition.

A year ago, when you installed me as your President, I told you that I hoped that a year hence, at this point, MSMA would be just a little better, just a little stronger. And I'm happy to report that this is the case. We've had a very good year... a very eventful year.

Of immediate interest, we've revamped the format for this annual meeting, changing from the 4-day schedule of recent years to this year's more compact 3-day schedule ... This has been a suggestion from time to time, and the Board of Trustees decided to try it. We'll all see how it goes ... If you like the change, or if you hate the change, let your trustee know.

MSMA enjoyed an extremely successful legislative session this year.

We achieved a substantial increase in the Medicaid physician fee schedule. After several years of no increase at all, the present schedule set all these years at 70% of the 1994 Medicare allowable charges, the new schedule will be 90% of the 1999 Medicare allowable charge, with a provision for automatic adjustments annually, in step with Medicare. This is estimated to increase the aggregate payments for physicians' services by about \$45 million this year.

This year's step in the longer-term development of a statewide trauma care network has been fully funded.

The Children's Health Insurance Program (CHIP) has been expanded this year, so that children in families with incomes up to 200% of the federal poverty level can purchase private health insurance.

Underpinning the above programs and expansions was the huge tobacco award to the State. These tobacco monies flowing into Mississippi for the next 25 years or so will go into a Trust Fund, 100% of the principal to be inviolate, invested, with the annual income on this ever-increasing principal to be appropriated for Health Care purposes. This is a huge amount of money. I will come back to this later.

Early in the session this spring our lobbyists were successful in quietly snuffing out several of the usual scope of practice expansion efforts by some of the usual groups --- this year optometrists, who wanted the legislature to authorize them to prescribe medicines, do LASER surgery, etc. -the usual stuff --- and podiatrists, who thought they'd like to do ankle and knee surgery. These are annual efforts at incursion into the practice of medicine by these assorted practitioners... Unfortunately we have to expect this type of thing every year.

The Mississippi Physicians Care Network (MPCN) has had a very good and an eventful year. Some high points of this project include

- 160,000 covered lives.
- 3,000 Mississippi physicians in our statewide panel.
- Over 100 hospitals contracted with our network.

A major change in the operation of MPCN is underway: Whereas from the inception of this project we have contracted with an outside management company for administration, we presently are bringing MPCN management in-house. Importantly, this step will allow us to capture information necessary for effective management, and it will bring an income stream directly into MPCN.

MPCN was a finalist, along with Blue Cross-Blue Shield, for the entire State employees and teachers plan—you remember, we've had approximately a third of this group under the "Base Plan" for the last several years—but, unfortunately, BC-BS won the competitive contract; however, even without this state group, we still have over 125,000 "covered lives"—don't you hate that phrase? I do—patients in all areas of Mississippi, whose health care expenses are covered by their employers' self-insured plans, contracted with and through MPCN. This project is in robust condition.

You all are aware of Mississippi's very successful disabled physicians program, which has been headed, since its inception, by Dr. Ellis Moffitt, who parenthetically is a personal hero of mine. Well, Ellis wants to hand over the reins as Medical Director of this program. Arranging for this transition has been more complex than you'd probably expect, but MSMA this year has concluded negotiations including the State Licensure Board, the Legislature, and the Disabled Physicians Program itself, arranged funding to pay a full time Medical Director, who will be selected by the MSMA Trustees; and presently is in the process of selecting Dr. Moffitt's successor.

MSMA's membership numbers are up again this year. I like to think that this is because of the relevance of the activities of this organization to its members and to the needs of our profession in Mississippi.

About 18 months ago we accepted an offer to sell our old headquarters building, and we've built a new, very functional and very handsome headquarters on the Highland Colony Parkway parallel to and just west of I-55, between Madison and Ridgeland. Please come and see your new headquarters. We're moving in next week ... We'll be announcing a grand opening this summer.

I don't feel as confident as that Greenwood florist, regarding his role in bringing that wreath to perfection. Indeed,

MSMA is not perfect yet... and it never will be. It is a work in progress. I can tell you that we have a fantastic staff, from top to bottom, seriously committed to making this Association work for us members. It has been an extreme pleasure for me to work this year as your President and to contribute what I could to this organization and thereby to our profession.

It's traditional for the departing President to make suggestions for future activities. I have only three specific things in mind:

We need to continue to upgrade the capabilities and competence of MPCN. I am convinced that this is the most important project that the Association has undertaken during my active involvement, and it represents one of our greatest opportunities to influence in a positive way the quality of health care in this state in this current environment of managed health care.

The opportunities opened up by the huge amount of money which will be available through the tobacco trust fund are mind boggling. As a profession and as an organization, it is incumbent upon us to assert leadership in how these funds are used. As it now stands, the money will be appropriated annually by the Legislature, and we can work in that arena, but our efforts need to be coherent and well considered. I suggest that MSMA establish a task force to formulate sensible proposals to use this money in constructive and meaningful ways ... to take optimum advantage of this unique opportunity to impact significantly the quality of health care in Mississippi.

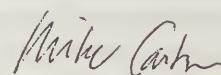
My last suggestion may seem at first blush to be mundane, and in fact it is simply a reaffirmation of present policy and procedure. I am asking that we, and our colleagues at home, take seriously our duty and our opportunity to serve personally on juries. For us to participate on juries will have more ramifications than come immediately to mind. Beyond our individual ability to contribute to the competence of a particular jury, if we trouble ourselves to serve, we will be less likely to excuse our patients from jury duty for doubtful reasons. We all decry the poor quality of our court system, and this is one thing each of us can do to improve things in this area.

Last year my friend Alfio Rausa introduced a resolution to the MSMA House of Delegates, concerning "the common thread" within the Medical Profession, and I'll have to say that though it is often not easy to see immediately what Alfio is getting at, this resolution was especially opaque to me. The resolution passed, and we pushed it through the AMA House of Delegates as well, but the idea still remained a little fuzzy. This "thread" continues to elude clear exposition for me, but I am getting closer to understanding what he was getting at. Last summer, one of our newest Trustees, Dr. Dwalia South, published a poem in the MSMA JOURNAL illuminating Alfio's idea.

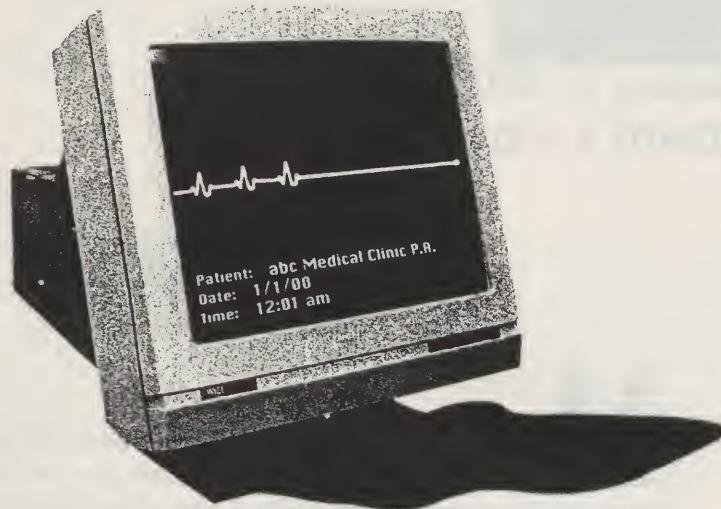
Recently I came across a short poem by the late William Stafford, my favorite modern poet, and I'd like to read it in closing:

### THE WAY IT IS

There's a thread you follow. It goes among things that change.  
But it doesn't change. People wonder what you are pursuing.  
You have to explain about the thread. But it is hard for others to see.  
While you hold it you can't get lost.  
Tragedies happen; people get hurt or die; and you suffer and get old.  
Nothing you do can stop time's unfolding.  
You don't ever let go of the thread.



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## **W. Briggs Hopson, Jr., M.D. The President's Page**

### **Thanks**

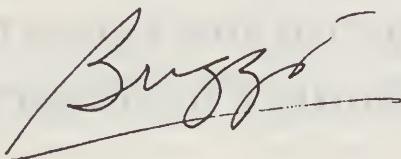
**M**any years ago as a young child, my mother told me two words that should be said, but are often not said, are "please" and "thank-you." As I assume the presidency of the Mississippi State Medical Association, I want to begin by saying THANK-YOU to all of you who practice medicine in this state and belong to our Mississippi State Medical Association and our AMA. You indeed are the backbone of medicine not only in this state but the backbone of medicine in this country. Thank you for believing in organized medicine and what unity can accomplish. I know that I would not hold the office of president if it were not for all of you who instructed and asked your delegates to vote for me in last year's delegates meeting. It is the greatest honor that I have ever been afforded, and I am not only pleased that I have this opportunity to represent you but my hope throughout this year is that I can represent you in all aspects of medicine in which you would have me represent you, both from the standpoint of lobbying for you in the legislature to talking with colleagues across the country about our fantastic Mississippi State Medical Association and the practice of medicine in our great state.

Let me also say a special thank-you to your spouses, our wonderful alliance, who are recognized throughout this country as being one of the best alliances in the United States, and who continue to provide monies for education, opportunities for young people to pursue and enhance their careers, and charities that would go unfunded if it were not for them. They continue to stand by our side and support us in all of our endeavors.

Also, another special thank-you goes to each of you who belong to our political action association. Without your help in this area, it would be impossible for us to get legislators elected who represent our ideas and ideals in medicine. I hope that each of you who reads this will make an effort to contribute to the AMPAC and the Mississippi Political Action Committee this year. It is a small token to pay to exert as much influence politically as it does. Only 30% of our members belong to this organization. Think of what we could do if 50% or 100% belonged. Please if you do not belong, think of contributing in this election year.

Certainly, last but not least, an extra special thank-you goes to the members of our executive team at the MSMA headquarters. Over the past year I have come to appreciate each of them more and more. They do a yeoman's amount of work with a limited staff, and let me assure you that they represent each of us wherever they go and in whatever they do. Any time anyone needs statistics information or data, they are more than willing to help and more than willing to go the extra mile for us as physicians.

As I conclude, let me again say thanks for this opportunity, and please let me know if I can help you in any way this year as I serve as your president.



*W*

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# An Interview with Todd Coulter, M.D., Member-At-Large on the Governing Council of the AMA Young Physicians Section

Karen A. Evers

**A**t a time when the United States is involved in the crisis in Kosovo over demigod social/racial issues and the television drama "E.R." has just depicted medical care in the South as being stuck in the Dark Ages, it is refreshing to meet a Mississippi physician like Dr. Todd Coulter. Having never met Dr. Coulter before, the only things I knew about him were that he was a leader in the AMA Young Physicians Section and had a reputation of being a tireless worker so I checked his MSMA membership file for more... and then I met him at his urgent care clinic, StatCare, in Ocean Springs to get to know him.

**Harold Todd Coulter, M.D. graduated from the University of Illinois Medical School in 1992 and then completed his training in Internal Medicine at Chicago's Michael Reese Hospital in 1995.** "I had always wanted to do private practice, internal medicine, obviously. And what happened is an interesting story. When I was a second year resident, I spent a month in Tylertown. Well, it's even more interesting, because my family is from Hattiesburg and Wiggins," Dr. Coulter said.

**Your mother was born in Wiggins.** "Yes, from the time I was age one to three, I lived in Wiggins. I was born in Virginia because my birth father – unfortunately he left my mother. They were living in Norfolk, Virginia at that time. And, this is public record. I mean, he never saw me. He left my mother while I was 'in utero'. So my mother had me, and I went to live in Wiggins, Mississippi with family

while she went to Chicago for nursing school. And if you remember, there was a massive migration of African-Americans from the South to the northern cities during the time of civil rights, and she participated in the Project Manpower Program, which was the forerunner of the Affirmative Action programs which were looking at getting more African-American people involved in mainstream jobs. So this is how she was able to go to LPN school. Well, she always made the comment that the reason why she went to nursing school was that (1) she wanted to help people and (2) so that she and I could eat. She later met my stepfather, who is the only father I have ever known, who is also the father of my two younger brothers."

**So, what's the rest of the story?** "Well, basically my story is kind of simple. I pretty much grew up a rather staunch Roman Catholic. And medicine for me, although I truly love this profession, was a second choice. I wanted to become a Catholic priest. And this is very interesting because there are some things that you won't see in this office that you would have seen in my other office. I have been to Rome to meet the Pope."

**How did you arrange that?** "March 29, 1998, I went to Rome. I accompanied His Excellency, Bishop Joseph Howze, who is the Roman Catholic Bishop of the Diocese in Biloxi. As you know, Mississippi is separated into two Catholic Dioceses. One is the Diocese of Jackson-Natchez under the leadership of Bishop James

Houck. Here it's Bishop Howze. Bishop Howze happens to be a patient of mine in private practice and I asked him if I could accompany him on his *ad limina* visit which is the every-five-year visit the presiding Catholic Bishop must make to Rome to report on the state of his Diocese to the Holy Father. During this visit, I had the opportunity of having a three-minute audience with His Holiness, Pope John Paul II. It was a wonderful visit; it was truly a wonderful visit."

**I heard that you had your picture made with His Holiness.** "Yes. This is the thing (the photograph) you will just not see in any other doctor's office here. I wanted to be a priest. And what happened was, in the late '70's, there were a large number of programs started in big

Chicago Area Health and Medical Careers Program. Well, through this program I was involved in classroom study on the weekends all the way through high school for four or five years. I went to the minor seminary of the Catholic Archdiocese of Chicago, a school called Quigley Preparatory Seminary South. Basically, my high school education was extremely classical—Latin, Greek, French, mathematics and calculus. I could read Latin. I mean, it is an unbelievable background. However, what happened was, I really got interested in medicine because I saw more African-American people like me in medicine. When you are a young high school student or college student and one of your mentors is an intern at Cook County and you have an opportunity to go spend time on call with him for five or six hours, it changes your perspective. I did not punt on the priesthood, but I saw God calling me in a different direction."

"Well, I did well. I went to Grinnell College in Iowa. I majored in Biology and Religious Studies. One of my big fundamental theses was the idea of the theodicy, which is the concept of "putting God on trial."

The idea of

looking at the relationship between the tragedies of our life and the inherent hand of God. Whether these things are implicit of God or not. The second issue was the concept of liberation theology. And I took the bent of someone like Dr. James Cone who talked about liberation theology from an African-American perspective. How do we reconcile racism in the Christian church in light of the gospel of Jesus Christ? It is irreconcilable by defini-



Todd Coulter, M.D. meets Pope John Paul II in Rome.

cities, particularly in Chicago, looking at trying to increase the number of minorities interested in health care professions, particularly medicine and dentistry, podiatry and optometry. One of these forerunners was called the Project 75 Program. By 1975 they wanted to have 10% of all medicine school admissions be African-American/minority. Well, that never came to fruition. But I participated in a program called CAHMCP which is the



Dr. Todd Coulter runs the Coulter Clinic, P.A. in Pascagoula and two urgent care clinics, one in Pascagoula and a newer one in Ocean Springs.

tion from a systematic theology point of view. I also majored in Biology, by the way, which was kind of interesting. I mean, it was really a pre-med preparatory stage."

**Your biology major must have been beneficial entering medical school.** "Well, it was. But, it was interesting because my natural tenets were to do other things. Anyway, I went on to the University of Illinois Medical School. I graduated from there and went on to Michael Reese. Like most medical students, I was \$89,000 in debt and I was looking for a place or a community anywhere that would be willing to say, 'Hey, doc, can we pay off your loans?' Well, I thought about the Public Health Service. So I ended up talking to a few friends who were in Mississippi and they said, 'Listen, what about the small clinic in Tylertown? You can go and spend a rotation there your second year for a month and see if you like it.' I figured, why not? Tylertown was

about 60 miles from Hattiesburg, where I had family, lots of family, *lots of family*, and from Wiggins where my brothers and I still owned a house. My mother died when I was a third year medical student. So I went to Tylertown and spent a month there. I worked at the SHARP Clinic, the Southwest Health Agency for Rural People. I was working there with Dr. Sharon Collins who is still an attending physician at that practice there. I lived in McComb and I commuted back and forth to the Holiday Inn. That was a turning point for me for Mississippi. Because if you recall 1993, it was about seven months before that the movie *Mississippi Burning* came out and you can imagine everybody and their mother was concerned about 'Oh, you don't want to go to Mississippi, you don't want to go to Mississippi.' Well, I am not necessarily a Republican, but I support the leadership of Governor Fordice when I make this statement: Mississippi – no bad words spoken. We don't want to hear of people who want to speak against this state."

**Did you see "E.R." Thursday night?** "I heard about it. Negative depictions and racial, irrational stereotypes are unacceptable. Things like that are just reprehensible and they don't do anything to serve the public good. Anyway, let's not even talk about that. It just irritates me that people would paint us with such a negative brush continuously. And I tell you, my car broke down in Mississippi late at night in McComb and I knocked on someone's door. Not only did they invite me in for the proverbial sweet tea, but they also called the car dealer who came to their house, took my car, and then took me to my interview at the McComb Hospital. Unbelievable, that would not have happened in Chicago."

**Well, it is good to hear that that was not the experience you had.** "Let me tell you, it is better than you realize. I would not leave Mississippi. No. In fact, I can tell you this. There is not a dollar figure that would get me out of Mississippi. The only way I would leave here would be if I felt that this is not my next assignment, where God wanted me to go and do something else. I have been traveling through the Delta on mission trips. I don't have any problems in this state. I mean, I am a duly licensed physician in the state of Mississippi. I know doctors from the Association. I figure this way. I know doctors everywhere in this state. You can go and talk to anybody and we are just more connected here than we are in other places, I think. But let me tell you what happened. After I spent my month in Tylertown, I figured I could go to a rural health area and be willing to serve. Well, the Singing River Hospital System heard about this young

doctor who wanted to come down to Mississippi. Very honestly, my third year in Residency, they offered me an opportunity I could not refuse. So I ended up in Pascagoula, Mississippi, July 1, 1995. During that time, relationships with hospitals changed a little bit; but, nonetheless I matriculated in terms of maintaining a private practice in Pascagoula. And I have also become somewhat of a dean, if you will, of urgent care medicine along the Coast. So I chair two different urgent care clinics along the Coast also."

Dr. Todd Coulter examines a patient at the StatCare Urgent Care Clinic in Ocean Springs. The patient, from Missouri, had contracted bronchitis and a bad sunburn after a day on the golf course during his Spring Break.



**Is the other urgent care clinic in Pascagoula, too?** "The other one is in Pascagoula, too, right."

**Are you still on staff at Singing River?** "Still on staff at Singing River, Ocean Springs, emergency medicine staff at Gulfport Memorial, and provisional internal medicine attending staff at Biloxi Regional, because we just joined the staff there. In fact, our goal is to get on staff at all the hospitals because the area is growing. Everything is growing here."

**Is there an effort to recruit more doctors to respond to the growth?** "We are trying to recruit more doctors for Mississippi. I think the options for growth are unbelievable. In fact, I have been trying to get in touch with some of the chiefs of the department at University Medical Center."

**How did you get involved with organized medicine?** "I was involved with the medical student section for about one or two years in medical school at University of Illinois in Chicago. But I got involved in organized medicine really because of the Singing River Medical

Society. Unlike local medical societies across the country which are inundated with everybody over 60, ours isn't. Most of the doctors are 30-ish to 50-ish. And why that is important is... a lot of that has to do with Singing River Hospital. It brought in a lot of young doctors and the next thing you know we were all here at

the same time. And the other thing I will tell you about our Singing River local medical society is that it has been very inviting in terms of wanting to solicit involvement. I have never felt that I could not be involved in any area of the local medical society, or at the state level, either. So what has happened is that we had an opportunity to do a couple of things... (1) to get involved in the local meetings and at the state meetings, and (2) because someone like Dr. Roland J. Mestayer who chairs the Young Physicians' Section (YPS) for the state was not able to attend the AMA meeting last June in Chicago, I went to the YPS annual meeting. And when I went to YPS annual meeting, I ran for Member at Large and I got elected!"

**I heard that was kind of a coup. That does happen occasionally. I remember when they wanted my father to run for the AMA Council on Medical Education. Daddy didn't think there was a chance that he could win. And he did. "And you go, 'Wow!' It was just unbelievable."**

**Well, I heard that you really had not planned**

**on running at all until you got there and some people started saying, "Hey, why don't you run?" "Why don't you run?" You know, I felt I was not an AMA-type. I said, 'well, you know, I don't know what all the different acronyms mean. I don't know all this other stuff.' And then I said to myself, 'why don't I run?'"**



Dr. and Mrs. (Dionne) Harold Todd Coulter

**So what is your official YPS capacity?** "I am Member-at-Large on the Governing Council of the AMA Young Physicians' Section. There is a Chair, a Chair-Elect, a Past-Chair. There is the Delegate, Alternate Delegate, and then there are two Members-at-Large. Right now, I am the most junior Member-at-Large until June when I will be the most senior Member at Large."

**How did you meet your wife, Dionne, or where?**  
"I met Dionne at Mass."

**In Chicago?** "No, no! My wife is from Moss Point, Mississippi!"

**Oh, I didn't know that.** "We attend the same church, St. Peter the Apostle Catholic Church in Pascagoula, and literally I was going up for communion and Dionne winked at me. No, no, no. I met her at mass. She is the most beautiful girl."

**I've heard she is very attractive.**  
"She is. She was 20 at the time. We have a 13 years age difference. I am 35. We have two children, Courtney age 8 and Katherine Dionne (Katie)."

**You have a new baby!** "She is 6-months-old as of tomorrow. And the world revolves around her."

**And you all reside in Pascagoula?**  
"Yes, we live in Pascagoula."

**You mentioned the opportunities provided by your local medical society, Singing River. What other opportunities for MSMA membership recruitment do you see?** "We recruit face-to-face about a half day a month. The girls in the office set up about five appointments for one-half day a month. Sometimes these appointments are on Saturdays. And what I want to do is start to work the Coast. There are 200 doctors on the Coast who aren't even in the AMA. Everybody wants to be President of the AMA. Everybody wants to be President of this association. Everybody wants these great jobs. What have you done? This is Todd Coulter's belief: *if you want to run for office, if you want to be active, then show your commitment.* The way we used to do it in ward politics in the old days in Chicago was,

if you wanted a job after the mayor got elected, how many people did you deliver to the polls?...same thing here. If an individual physician says, 'I don't want to do anything with AMA', then fine. There is nothing you can do there. But, they have had the personal contact."

"Hey, here is a good example. John Huntwork is back on board with the AMA. Dr. John Huntwork quit the AMA over an article published in **JAMA**. He is a member of the Pascagoula medical staff at Singing River Hospital. He sent me an emergency fax and a letter the day that the AMA fired George Lundberg and told me a parade of things and said he was going to quit. I immediately faxed

that to Bill Roberts and sent it to John Burkhart, our coordinator at AMA for the Young Physicians' Section. Well, Bill got it to Mike Carter, who got it to Ed Hill and John Huntwork got letters from both of them and from Bill. John Huntwork has now sent me a letter last week, and he has already carbon copied it to the other people saying he acted in haste. He recognized certain things and because of the coordinated effort and support and response that he got en masse, he is back on board. That happened because Todd Coulter did not just take the note and say, 'Aw, I'm sorry, John and toss it.' That is because I sounded the alarm."

**I remember when he called MSMA. He called before he wrote the letter and he was upset.** "That's right. But now he's back on board. He's back on board because we touched him. And now, he's an advocate. John Huntwork was a former State Senator in West Virginia. We are not talking about someone who is unassociated with the political process. You see what I mean? We need to get our arsenal together with individuals like that. We have got so many committed men and women of character and faith and conviction in the active practice of medicine who would be exemplary leaders in the American Medical Association and in our state association. There is no doubt about it. But I believe this rite of invitation has not really been extended. I don't think we have maintained the relationships that we have made.

#### **How would you suggest we improve relationships within our association?**

"Karen, I am very John Kennedy-like when I tell you, 'All politics are local.' It is not enough to improve our relationships with association members. Our MSMA, must take the lead to broaden and extend its influence, and commitment to service to non-member physicians as well. **If we lead by service, commitment and confraternity will follow!** We can't wait any longer for doctors to finally realize, how important MSMA, AMA, and unified state leadership is. We need to take the message of support, advocacy and strength to our non-member physicians, door to door, office to office, and hospital to hospital. I would love to help develop a core of doctors in the state that would be willing to do just what I am saying here- would be willing to go out and say to a doctor who applies to us, "Doctor because we believe in what our state association stands for, because we believe in supporting you, and keeping you taking care of the people of Mississippi, and because we recognize the invaluable work you are doing we are going to back you up."

"Karen, we've got doctors in this state working so hard in the trenches, they can't get away for CME's, attend family functions, or retreat to rejuvenate their marriages. That is unfair. It would be great if a core group of doctors would be willing to travel to Tupelo, or cover a practice in DeSoto County. Imagine the headline, "**Mississippi Doctors back each other up.**" I could choose to spend a week in Washington County so Dr. X could travel to New York to see his daughter graduate from college. Another doctor could travel to Sunflower County so Dr. Y can participate in a marriage renewal retreat with his wife of 25 years. Imagine, as MSMA members we continue taking care of their people. We continue providing care and service. We continue to back our doctors up. Some might ask what's the cost? What's the compensation? What's in it for me? Well, let me tell you, it's all a gift. Support, advocacy, strength and confraternity are all gifts. They are gifts of time, talent and treasure. Advocacy and support are more than just brow beating. To be the association that we are called to be, **we must lead.** This is what we need in Mississippi. We need selfless commitment across the board. It could be done so easily. If a guy like me can give up a day a month to go and recruit for the AMA, what's seven days a year when it comes to helping out a struggling colleague or a doctor who needs backup. We have to start thinking out of the box. We have to start leading by example. That is just the way I see it."

**That is a very interesting, refreshing, and novel viewpoint from someone who was not born here and is deeply Northern although you spent three years here as a child and your family's roots are here.** "I am deeply Roman Catholic. And with the antithesis of the past history of Mississippi, that is very surprising. But I don't believe in all that stuff. What happened in Mississippi in 1963? Mississippi in 1963 is not what it was in 1993. So, you know what? We are over that. Let's just keep moving forward. I mean, we should not be short-stopping in the state of Mississippi. There is no reason to. We have some progressive leadership. We have some great people who are in place. And we have people coming up through the pipeline in the association across the board here in the state."

**You have so much energy.** "This is where I am at. And, man, I'll tell you, some people think a part of this is the God of my understanding, part of this is the Catholic priest who is stepping in place. I have no hidden agenda. I have no ulterior motive. I am not out for anything. I am happy to be where I am at this moment. I am so happy that God put me here. I am so happy that I have my family. I

am so happy that I have met the people I have met. I am so happy that people like Vann Craig have taken me under their wing, anointed me, helped me. Let me tell you something. I have sat in three association meetings since I have been here, and I know this for a fact, I have been the only black person there."

**Why is that? I know that black physicians have their own separate medical association, The National Medical Association.** "Oh, yeah. But I think it goes back to the fundamentals. But I can also tell you that there have never been more than ten young physicians there either, at the MSMA annual meeting."

**You're correct. The majority of physicians attending annual session, at least for the plenary program, have been in practice over 20 years (60%) and only 8% in practice ten years or less.** "That's right. So, what are we talking about here? We are talking about invitation...an invitation. I can tell you that if we get an opportunity to begin the process of invitation, we will get more black doctors in the AMA, more black doctors in the State Medical Association. It is just a matter of time. I think there are some racial attitudes still prevailing on both sides of the aisle – black versus white. I think that exists. I think we are tearing down those barriers in the state of Mississippi and I am proud of that. But I also strongly believe that most of us have not been invited. I got involved in the Singing River Medical Society, not because I was black or white or green; I got involved in the Singing River Medical Society because the doctors I worked with said, 'Hey, come on and join the Medical Society.' And then I got involved. And that's the bottom line. I don't think those relationships exist. I think we have something special here in Pascagoula and, more importantly, in the Singing River Medical Society, our part, because you know the Coast has two societies...Coast Counties and Singing River. I believe the potential for developing those relationships exist. I have tried to utilize my position and whatever leadership that gives me in the Governing Council to serve as a bullwhip, if you will, to talk to other doctors across the state about getting active, getting on board. We need to go back and take care of the people in the trenches. One of the biggest concerns is that doctors are struggling right now. A lot of doctors are struggling. It is not like it was in the average practice. A lot of doctors are struggling and they don't need to struggle. There are things that young doctors need to be told. There are things that middle-aged doctors need to be told, that they need to get in perspective. Nobody is teaching them and nobody is letting them know about it.

I think if we start to channel all our efforts in that direction, it would make a major difference. I got something in the mail the other day from the University Medical Center they sent out to internists across the state, asking us very clearly, what are the things that we feel as private practitioners they should be training their house staff? They had some things on there that I said, 'Yes, absolutely.' And they had some things that were missing. That is what needs to be done, not just there but with our current doctors in the field. I have young doctors who are applying who have asked me, 'Listen, if I come and join you, can I come and work in the urgent care clinic, can I come and work in your practice?' I said, 'Sure, but there are some other things we need to know if you know about first.' This has to do with the survival of the practice of medicine from a business perspective. And that is not being taught."

**Give me some examples?** "I think every doctor should know how to fill out a HCFA form. I don't think most do. I don't think many can read an EOB. I really believe the average doctor should take advantage of 90% of the things that the AMA has. In fact, I just got this book from the AMA. I wrote for it, *Mastering the Reimbursement Process*. I wish I had read this book when I was a second-year resident. I probably would be \$60,000 ahead."

**And it is probably more important now than it was then.** "Absolutely. And I think one of the things is, we don't tell people this. In fact, this is the type of thing we should be giving away to our house officers. Instead of giving away *JAMA*, we should give them the book. This is what I am talking about. Someone like myself who has been in the trenches can tell you. This is what they need to know. I think we need to help young doctors become very realistic about the use of credit cards, the use of financial constraints. I think there are a number of things that, if they are not well-developed, men and women can find themselves in untenable positions. I believe there needs to be more mentoring. For example, when I first started my bank account here in Pascagoula, there was another doctor who called me and told me about four different banks. He is a member of the association. Why this bank versus that bank? Why consider these things? He taught me what a line of credit was. Every bank wanted to offer me a line of credit. My parents were working class people. They never had more than 500 or 600-dollars in their checking account. So what do we know about a line of credit? I knew about credit cards. I did not know anything about a line of credit. Well, you

know, this doctor taught me about a line of credit. How to use it, what it is used for. Not to live on but to help arrange the cash flow. Thank God this one doctor took that time and now, in retrospect, there are five or six other things I wish he had taught me. It would have saved me time, effort, and a lot of heartache. I pass this information on to young doctors who tell me they want to come on board. And I think we need to have a single voice in terms of passing on information. Part of that comes through mentoring. Because if you are pals with someone who can guide you on, it makes life a lot easier. And I don't know why men and women don't mentor to each other. But I am going to tell you, mentoring is taking care of the young. It is preserving everything we have gained. And that is what we do for children, don't we? We call it parenting, but it is mentoring. We mentor to them. We tell them this is the reason why you go to church, this is the reason why you go to school, these are the reasons why you obey the police, these are the reasons why you follow a civic order, these are the reasons why you don't do certain things. We need to continue to do that but we need to be more aggressive about it. We need to fundamentally, as Steven Covey says, develop a new paradigm. That is one of my main interests, so you got me going. I'm sorry."

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# The Confederate Hospital at Beauvoir: A Dream for Restoration

Karen A. Evers

**I**t has been said that necessity is the mother of invention. Perhaps for that reason many changes occurred in the medical profession during and following the Civil War. Former Surgeon General C. Everett Koop has referred to the Civil War as a "watershed in American medical history." Important innovations in medical practices occurred, including advances in anesthesia, sanitation improvements, triage and reconstructive surgery. The nursing profession changed to become a very professional occupation. An ambulance corps was begun.

Beauvoir, the home of Jefferson Davis, situated on 50 acres on the Mississippi Coast, is a National Historic Landmark whose history is tied significantly to medical history related to the Confederacy. The Mississippi State Medical Association (MSMA) and the MSMA Medical Alliance Directors recognize this and feel the restoration of the Confederate Hospital Building on the property is a high priority. The proposed restoration would preserve two important periods of medical history and educate the many visitors who come to Beauvoir each year. The medical community needs to be aware of the potential for adding an important dimension of medical history to the coastal experience for tourists and the need to memorialize those physicians and nurses who were a part of this history.

The Confederate Hospital Building was constructed as a hospital for Confederate veterans, their wives, and widows, who were cared for on the property beginning in 1903. Today, because of the opening of the magnificent new 13,500 square foot, two-story Jefferson Davis Presidential Library, the dream of a major medical exhibit can be realized. The new Library houses library materials,

artifacts and offices which formerly occupied the hospital building. The opening of this new facility allows the focus of restoration activities to turn to the Confederate Hospital Building.

Beauvoir provides fertile ground for telling the exciting history of two important periods of medical history. The first is the story of medical history during the Civil War. The second is the period of 1924-1952 when the use of the facility was for Confederate Veterans and their widows. Both periods are robust with turning points in medical history and personal stories that will engage the public and teach the drama of medical innovation and progress. The total cost of the project is estimated at \$1.5 million dollars.

The exhibit will be designed to demonstrate the significant connection of Beauvoir, particularly the Confederate Hospital Building, to medical history. That history will be outlined with key events and photographs which illustrate these events. Beauvoir archival materials will be noted, as well as a list of needed artifacts.

By creating awareness of this upcoming project, it is hoped that increased involvement and ownership of the project will be the result.

The MSMA Alliance has taken on the project as a continuing one as they participate in the renovation of a 1924 hospital and help to provide medical exhibits in the museum setting at Beauvoir.

According to historical interpreter Martha Clippinger, "The Alliance project relates to medicine and the Confederate soldier during the War between the States and to medicine and the Confederate veteran



The front entrance to the Beauvoir museum building which is shaped in a cross.



The back side of the museum shows the sun-porch ward patients used when Beauvoir served as the Confederate Veterans Hospital.



The Gulf waterfront at Beauvoir during the 1880's resembled an eroding river bank and boasted a bench platform near this site and a substantial pier and boathouse near the Western boundary of the property.

during the years the building was operated as a hospital." The building is now a Soldiers' Museum but will be renovated and new exhibits will be installed.

As a result of informal discussions with several local doctors and wives, the possibility of medical exhibits at Beauvoir led to a presentation to the Board of Directors, Mississippi State Medical Alliance in May, 1997. It received approval and the president appointed a Study and Research Committee. This committee met

in August, 1997. Their recommendations were presented to the Board of Trustees of the Mississippi State Medical Association, where the project received endorsement in October, 1997. In January, 1998 several members of the committee traveled to Pensacola, Florida, to visit the Civil War Soldiers' Museum owned by Dr. Norman Haines. "Dr. Haines has a large collection of medical artifacts on display which we found very interesting," Mrs. Clippinger said.

The next step was locating a larger core group of doctors and wives who would actively assist in developing the committee's ideas. Mrs. Clippinger, wife of Gulfport family practitioner David Clippinger, said, "A list was made of approximately thirty couples whom we thought might be interested and invitations were sent. The event was a twilight picnic on the porch of Beauvoir on April 30. There were twenty present and most were enthusiastic in their support."

"By happy coincidence Beauvoir is engaged in a capital campaign designed to create an endowment fund for the institution. They have employed the firm of Whitney Jones, Inc. of Winston-Salem, North Carolina, to promote the campaign and Martha Fleer of that company was available to assist us in planning. She has done all our clerical work for us as well as all mailings," Mrs. Clippinger said.

Their second meeting continued the planning and they heard JaNeen Smith, Executive Director of the National Museum of Civil War Medicine in Frederick, Maryland, tell about that institution.

At their third meeting they each took the responsibility of contacting four doctors regarding financial gifts and pledges.

"Our first gift was \$1,000.00 and the second was \$5,000.00. At their meeting on August 20 Coast Counties Medical Society gave our third gift - \$5,000.00 and pledged to continue giving to the fund. Our goal is \$200,000.00," Mrs. Clippinger said.

"The Mississippi Hospital Association has offered enthusiastic support and donated a picture of the operating room at Tripler Army Hospital, Honolulu, dated 1930-35. It will be the basis for our operating room restoration. Mid-America Medical is a company which buys and sells used hospital equipment and they have volunteered to assist us in locating what we need. We already have the operating table and a Gomco suction machine as well as a 1936 cystoscope," Mrs. Clippinger said.

The second part of the planned exhibit will be a diorama of a field hospital from 1863. It will offer many ways to contrast the medical care available at that time

with that available in the 1930's.

"Considering the care available then they maintained pretty good records for that era," Mrs. Clippinger said. For instance, In 1925 Dr. Fred S. Gay was the surgeon in charge of medical care for Confederate Veterans living at Beauvoir. He was paid \$4,800 annually. He recorded 1,178 visits and examined 108 on admission to the home. The average hospital census was 75. There were 115 deaths," she said.

These records and exhibits will offer unlimited educational opportunities to the 75,000 annual visitors to Beauvoir, many of whom are school children. They will also offer a means of recognizing and honoring the dedication of members of the medical profession.

If you would like more information about the hospital museum or would like to donate medical artifacts or money contact Martha Clippinger at (228) 896-4156.



Among the artifacts on exhibit are (E) a pocket surgical kit belonging to Dr. George Keith Birchett and typical of those used to treat wounds in the field and (A) a capital operating kit used by Confederate Surgeon J. M. Hunt of Vicksburg, Mississippi. The kit contains instruments used in the amputation of wounded limbs, trephining, or cutting into bones, and other surgical procedures.

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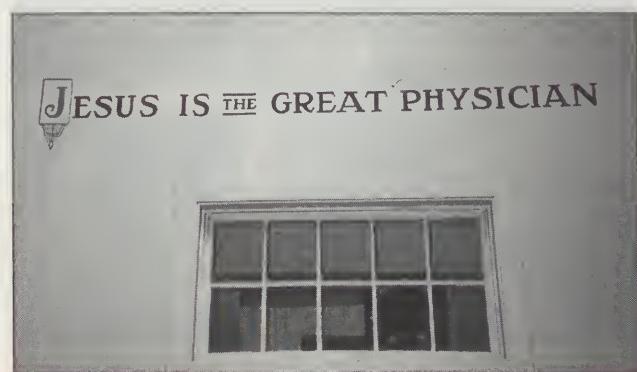
The history of medicine is a story of knowledge... in Biloxi, Mississippi, in 1861-65, and it continues on as we prepare to begin the restoration of a 1924 hospital and help to provide medical exhibits in a museum setting at Beauvoir, the Jefferson Davis home.

The project offers many educational opportunities to the 75,000 annual visitors to Beauvoir. Development of the dream began with an invitation.

Field Hospital  
A new exhibit will be based on the service

Plaque Notes

The MSMA Alliance won third place in Southern Medical Association's competition for their ongoing project.



Patients at the Confederate Veterans Hospital painted epitaph murals on the walls.



Other artifacts on exhibit include (F) a mortar and pestle used for mixing medicines, (G) a mess kit used by Surgeon J. Josiah of the 22nd Maine Infantry Regiment (D) scales used for measuring prescription medicines (B) a pharmacy chest of the type used in military hospitals and (I) an oil lamp and oil supply can believed to have been used in a hospital.

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## ENDANGERED SPECIES

It's thought to have gone the way of the dinosaur and the do-do bird. But because it was recommended as an educationally-enriching activity, I was determined that during his Family Medicine preceptorship my medical student would experience the historically sacred yet recently elusive "House Call" (whether spontaneously or pre-arranged).

House calls served a definite purpose in an era when transportation, communication, and technology were less sophisticated and the medicolegal climate less stormy. Such vigilant visits advanced the image of the physician as the compassionate caregiver whose bottom line was more than likely the one securing the saddle to his horse.

A distinguished photograph of turn-of-the-century Attala County physicians displayed in my office caught the eye of an octogenarian patient who pointed to one of the figures and exclaimed, "He took out my tonsils on our kitchen table when I was a young girl!" It seems that perhaps in leaner years (and certainly before the days of CEJA) this entrepreneurial practitioner canvassed the countryside boldly hawking his services via a bullhorn mounted atop his Model-T.

Well, with my extern's days in "LMD-Land" numbered and the prospects of a bona-fide house call fading, potential candidates were quickly considered and the choice narrowed to an elderly homebound widow whose health history legitimized her selection. Besides, I rationalized, since she had no immediate family in the area, she might enjoy "company"!

The vulnerability of the elderly was poignantly underscored as this vision- and hearing-impaired lady allowed us entry into her humble home without initially recognizing me. However, after a few awkward moments, the visit settled into a comfortable pace with the patient in a loquacious mood. After explaining her conscious decision not to remarry after her husband's untimely death of a heart attack while mowing the grass some thirty years ago, an intriguing account unfolded of their courtship and marriage.

Late in the school year this sixteen-year-old picture of innocence arrived to find her classmates abuzz. Led to her desk, she discovered the initials "GM and CMW" inscribed in green ink (which everyone knew was used only by their first-term twenty-year-old male teacher). Mrs. M. recalled, "Needless to say, I was shocked because his behavior had never been inappropriate and my marks certainly weren't any better than I deserved!"

As it turned out, her father was one of the school trustees responsible for approving teacher contracts. Making certain that he had secured her father's signature on the dotted line, Mr. M then screwed his courage to ask if he might court the daughter. Not only did this request fall on deaf ears but Mrs. M.'s father held her out of school the following year!

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

With the surreptitious aid of her sympathetic aunt and uncle who proclaimed Mr. M. a worthy suitor, this unlikely couple "courted" by meeting on Saturdays in downtown Kosciusko in the romantic setting of either the grocery or the five-and-dime ... for three years! Finally, Mr. M. announced, "I'm thinking about getting married. Would you be interested in joining me?"

So a bold plan was hatched: With the blessing of her aunt and uncle who would serve as witnesses, Mr. M. would drive his auto to the foot of the hill (after Mrs. M.'s unsuspecting father had gone to the field) and she would join him ... unless it was raining. "I didn't even buy a new dress," Mrs. M. remembered. "I just picked a nice Sunday outfit I already had." On the appointed day, she awoke to bright sunshine, and the rest is history!

After a perfunctory physical exam to fulfill the requirements for a "real" house call, the medical student and I bid Mrs. M. farewell, realizing that we had been the lucky beneficiaries of this visit.

—Stanley Hartness, M.D.  
Associate Editor



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# Readmission Program Integrity Pilot Project

**James S. McIlwain, Jr., M.D.  
Barbara Moore, M.A.  
Joyce Partridge, R.N.  
Debbie Miller, A.R.T.**

I.Q.H. participated in the readmission program integrity pilot project using the quality improvement approach rather than the traditional case review. The goal of the project was to determine the cause for Mississippi's high number of readmissions and reduce the number of inappropriate readmissions using quality improvement principles.

## Methodology

- Claims data for calendar year 1996 and seven months of 1997 was analyzed.
- A committee including physicians and I.Q.H. staff was convened to analyze the data.
- From the top 20 hospitals with both high volumes of 15 day readmissions and readmission rates higher than the national average, seven were selected for inclusion in the project. Two hospitals selected had the highest volume of readmissions with subacute stays.
- An abstract for capturing the data was developed.
- Records (753 readmission pairs) from the seven selected hospitals were screened by nurse reviewers using Interqual Admission and Discharge Criteria. Physician review was performed on pairs not meeting criteria. Pairs were categorized as appropriate and unavoidable, avoidable due to utilization, or avoidable due to quality of care.

- Analysis of the data showed four of the seven hospitals had a pattern of potentially avoidable readmissions.
- A letter was sent to the administrator of each of the four hospitals explaining that the hospital had one of the highest readmission rates in the state and that I.Q.H. had chosen to handle the project through quality improvement methodology rather than issue denials. The results of the data abstraction from the hospital along with the review physician comments were provided.
- Project guides including quality improvement principles, sample improvement plans, and time lines for completion were developed and sent to hospitals.
- Continuous contact was maintained, and onsite visits were made when requested.
- Monthly discharge lists provided by the hospitals were used to calculate monthly readmission rates and to identify readmission pairs for remeasurement utilizing the same process for data abstraction that was used initially.

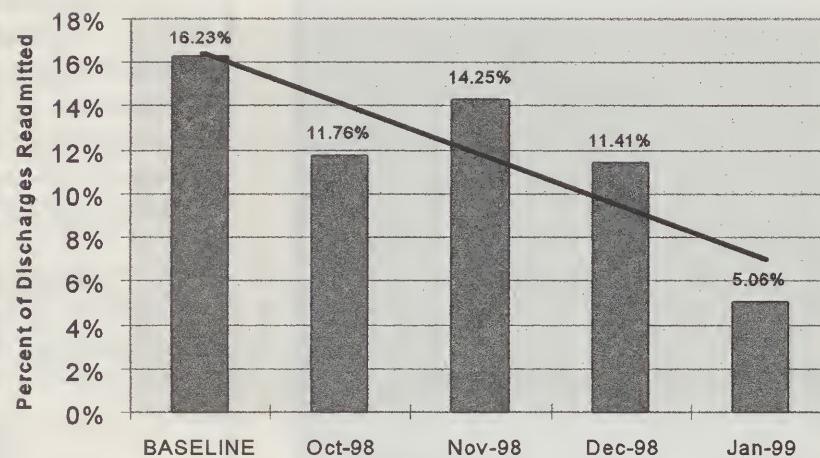
## Conclusion

The following graphs show the monthly readmission rates during the remeasurement period compared to the original readmission rate and the improvement in the percentage of inappropriate readmissions during the remeasurement period. I.Q.H. believes the success of this

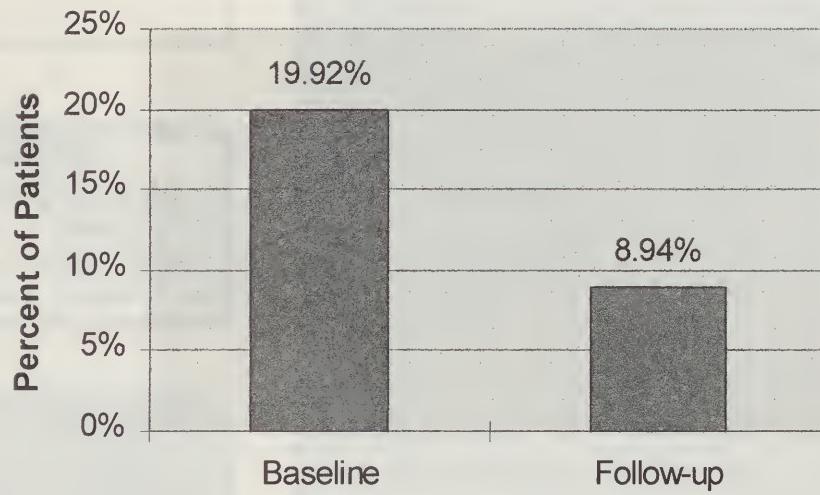
pilot project and lessons learned can be applied to the payment error prevention program (PEPP) which begins with the Sixth Scope of Work in August 1999. Collaborating through a quality improvement project methodology can be successful.

*The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Dept. of Health and Human Services. The content does not necessarily reflect the view or policies of the Dept. of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of ideas presented. The article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care and therefore required no special funding on the part of this contractor. Ideas and contributions concerning experience in engaging with issues presented are welcomed.*

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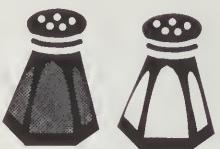
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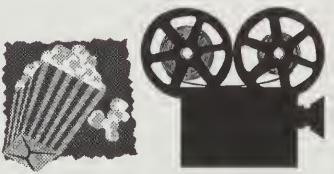
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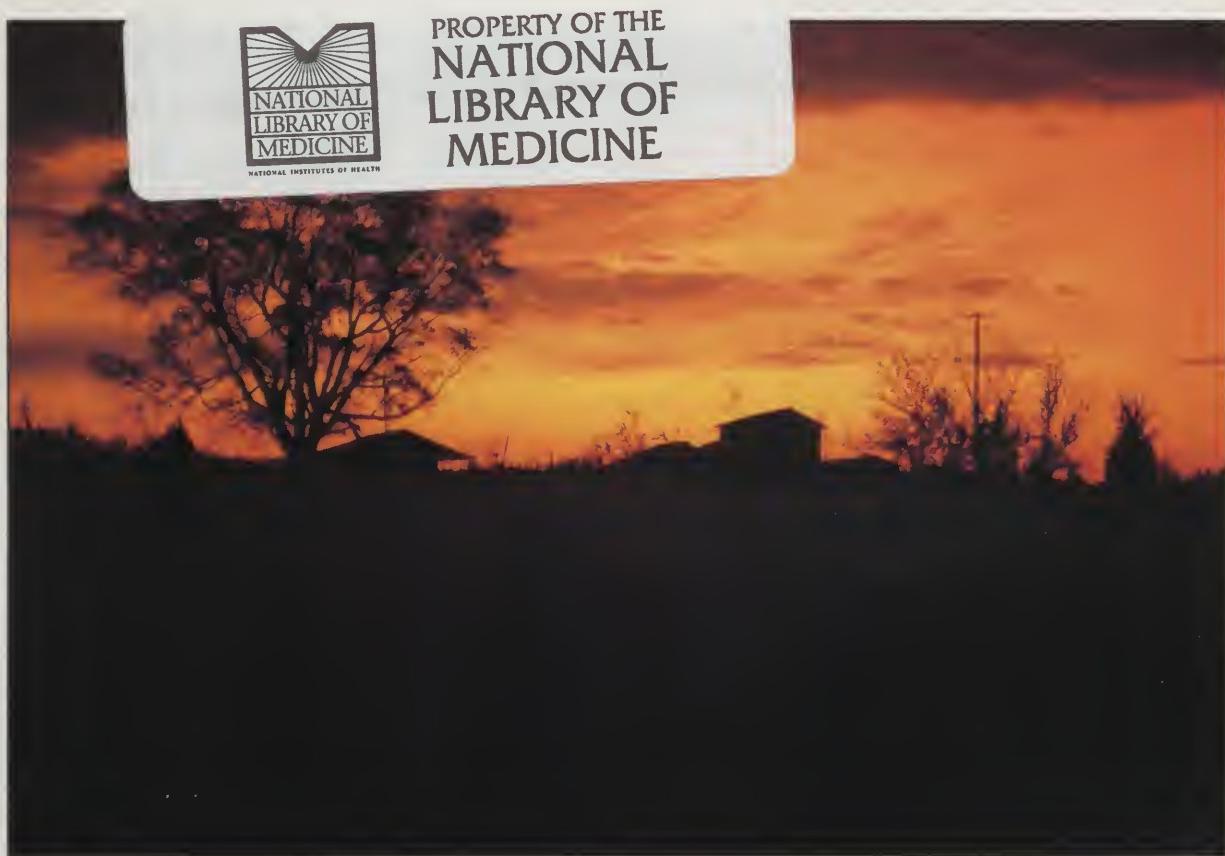
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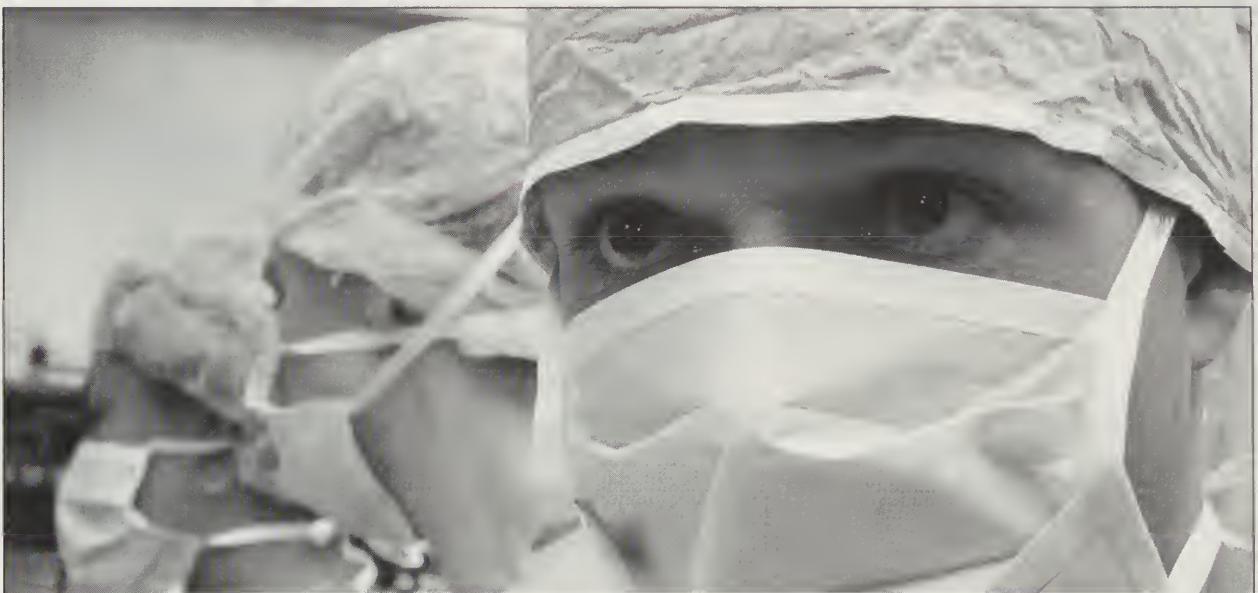
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# A Community-Based Case Management Model for Hypertension and Diabetes

Monroe Ginn, M.A., Research Assistant  
Dennis A. Frate, Ph.D., Research Professor  
Lela Keys, B.A.

## A bstract

Health research conducted over the past 15 years in the Mississippi Delta has continually documented a population experiencing poor health status (high rates of chronic diseases and excessive related mortalities). Both individual and health system resources are scarce in this region, posing barriers to effective chronic disease management. Two of the most significant chronic diseases that burden this population are hypertension and diabetes. To address this issue, the Delta Community Partners In Care project centering on chronic disease control was developed by a consortium of local health care institutions and supported by a national foundation. The intervention model centers on the utilization of a community-based case management approach in 13 clinical sites. Both compliance to pharmacological and individualized nonpharmacological therapy and continuity of care are stressed. A number of outcome measures showed significant improvement over the 24 month project period (N=756).

### Key Words

Case management  
Diabetes  
Hypertension

### Introduction

Chronic, noninfectious diseases dominate the morbidity patterns in the United States. Two of these disorders, hypertension and diabetes, are a population burden as

measured by treatment costs, mortality, and associated quality of life. Yet, we do know through a number of clinical trials that these diseases are controllable and/or manageable through pharmacological and/or nonpharmacological therapies. The problem continually encountered to such life-long drug therapies and/or lifestyle modifications is that compliance is not an easy goal to achieve. Consequently, in the United States we are still faced with the problems of end-organ damage that are associated with these disorders being uncontrolled. Current end-organ morbidity and mortality patterns, such as coronary heart disease, cerebrovascular disease, renal failure, and amputations provide evidence of the clinical significance of these uncontrolled disorders.

The population burden of hypertension and diabetes is especially exaggerated in the South where prevalence rates of these disorders are estimated to be the highest in the United States<sup>1</sup>. In addition to experiencing high prevalence rates, rural populations in the South also face a number of barriers affecting access to health care; these barriers which obviously hinder the management of these as well as other clinical disorders include:

- 1) the maldistribution of primary care providers;
- 2) the high proportion of uninsured and underinsured residents;
- 3) transportation restrictions; and,
- 4) social and health care system restrictions, including resident education, health belief systems, and

the presence of multiple chronic and acute disorders or comorbidities.

In areas experiencing such barriers, chronic disorders such as hypertension and diabetes require a focused, accessible health intervention approach for effective disease management.

Any approach centering on the clinical management of these chronic disorders then must be designed to address and overcome these barriers. The Delta Community Partners in Care Project (DCPIC) was specifically designed to consider these issues. DCPIC as organized involves a number of significant stakeholders, including the provider community, the consumer community, a research institution, and an external funding agency<sup>2</sup>. DCPIC works in conjunction with the primary care providers to coordinate individual patient case management. The cornerstone of DCPIC is the specific community-based case management approach for chronic disease therapy developed for this area<sup>2</sup>. Case management is a model of health care delivery that grew out of the field of nursing to help patients manage their chronic illnesses<sup>3</sup>. The case management model has also been utilized to provide social services "to aged individuals with social, health, or economic problems that limit their level of functional independence"<sup>4</sup>." "Case management involves client assessment, care plan development, implementation, client service monitoring, and periodic assessment and evaluation<sup>5</sup>." Within the case management approach of DCPIC, issues of availability, transportation, patient knowledge of the disease process, and socio-cultural appropriateness of the therapy are addressed and are being overcome<sup>2</sup>. Through the indigent drug program, issues on reimbursement are addressed also. Case managers hired from the local community were trained in specific methods to educate and case manage patients with hypertension and/or diabetes. These case managers work under the guidance of the primary care providers to help patients adapt their primary care providers' recommendations into their lives. This program is currently being delivered in 12 ambulatory clinical sites and 1 hospital site in 5 Mississippi Delta counties.

## Methods

As of September, 1998, 1,168 patients are enrolled in the project. The data to be reported on in this presentation center on the second 12 month outcome measures. Due to staggered recruitment, this represents the evaluation of 754 patients. An evaluation of any community-based chronic disease intervention program must be designed to consider a wide range of measurable out-

comes beyond just the clinical management or outcome status. This evaluation included the statistical analysis of changes occurring over time in the patients' high blood pressure knowledge, diabetes knowledge, and self-perceived health status change as well as blood pressure control status and diabetes control status.

## Results

Table 1 illustrates that the knowledge of patients about hypertension has increased over time. The average number of correct responses to eight questions concerning hypertension increased significantly from the baseline measure (Time 1) to the second measure (Time 2). Knowledge about hypertension also increased significantly from Time 2 to Time 3. Both of these increases were statistically significant ( $P < 0.05$ ).

Table 2 provides the average number of correct responses to eight questions concerning diabetes. These responses indicate that patient knowledge about diabetes increased significantly from the baseline measure (Time 1) to Time 2 and from Time 2 to Time 3. These increases in patient knowledge about diabetes were statistically significant ( $P < 0.05$ ).

Table 3 reveals the change in patient health status for the better since last year. This was determined using a national standardized self-reporting measure. The percent of patients reporting an improvement in their health status increased significantly from Time 1 to Time 2. This increase in the percent of patients with an improved health status was statistically significant ( $P < 0.05$ ).

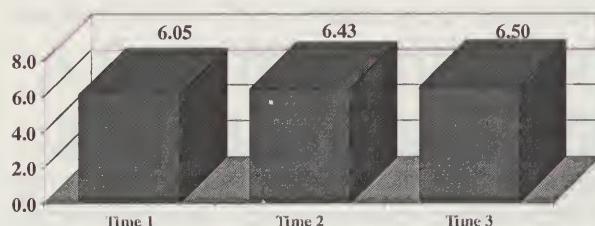
Table 4 illustrates the percent of patients with a controlled blood pressure reading (systolic pressure less than 140mm and diastolic pressure less than 90mm). The percentage of patients with a controlled blood pressure reading not only increased from Time 1 to Time 2 but also from Time 2 to Time 3. Both of these increases were statistically significant ( $P < 0.05$ ).

Table 5 provides the percent of diabetic patients with a controlled blood sugar reading (blood glucose reading between 60 and 120). The percent of diabetics with a controlled blood sugar increased from Time 1 to Time 2 and from Time 2 to Time 3. However, this increase was not statistically significant.

## Discussion

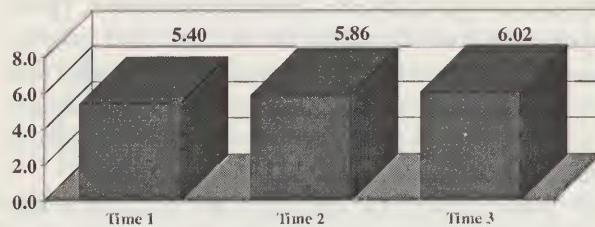
These initial results illustrate that a population that normally encounters numerous barriers to health care can effectively and positively deal with managing these chronic disorder(s). As the health care system in the United States continues to evolve, it must constantly be sensitive to the

**TABLE 1**  
**HIGH BLOOD PRESSURE KNOWLEDGE**  
**NUMBER OF CORRECT RESPONSES**  
(Average)



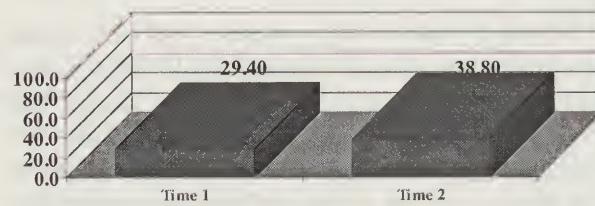
Time 1-2: Time Effect Significant ( $P<.05$ )  
Time 2-3: Time Effect Significant ( $P<.05$ )

**TABLE 2**  
**DIABETES KNOWLEDGE**  
**NUMBER OF CORRECT RESPONSES**  
(Average)



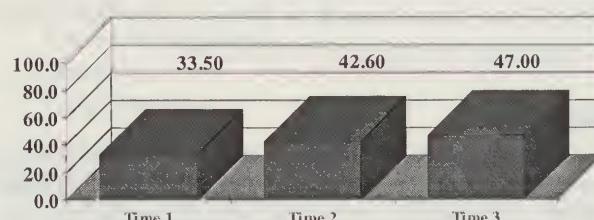
Time 1-2: Time Effect Significant ( $P<.05$ )  
Time 2-3: Time Effect Significant ( $P<.05$ )

**TABLE 3**  
**HEALTH STATUS CHANGE FOR THE BETTER**  
**SINCE ONE YEAR AGO**  
(Percent Better)



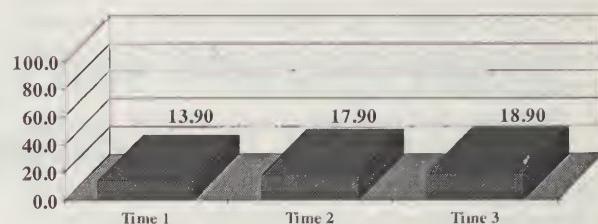
Time 1-2: Time Effect Significant ( $P<.05$ )

**TABLE 4**  
**BLOOD PRESSURE CONTROL STATUS**  
(Percent Controlled - BP<140/90)



Time 1-2: Time Effect Significant ( $P<.05$ )  
Time 2-3: Time Effect Significant ( $P<.05$ )

**TABLE 5**  
**BLOOD SUGAR CONTROL STATUS**  
(Percent Controlled - BS=60-120)



facts that: 1) with certain populations, numerous barriers to health care are encountered; 2) community-based chronic disease control activities can be designed addressing those barriers; and, 3) benefits to the patients and to the system (costs) can be achieved through such community-based disease management programs that collaborate directly with the primary care provider community.

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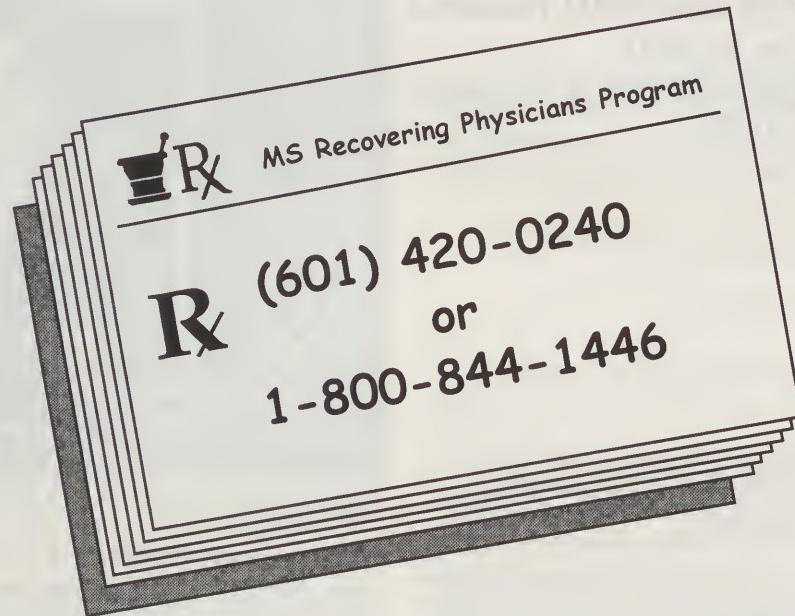
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# The Mississippi State Medical Association 2000 - History Does Repeat Itself

**Address of the 1999-2000 MSMA President**

**W. Briggs Hopson, Jr., M.D.**

**131st Annual Session House of Delegates**

**Sunday, May 16, 1999**

**Biloxi, MS**

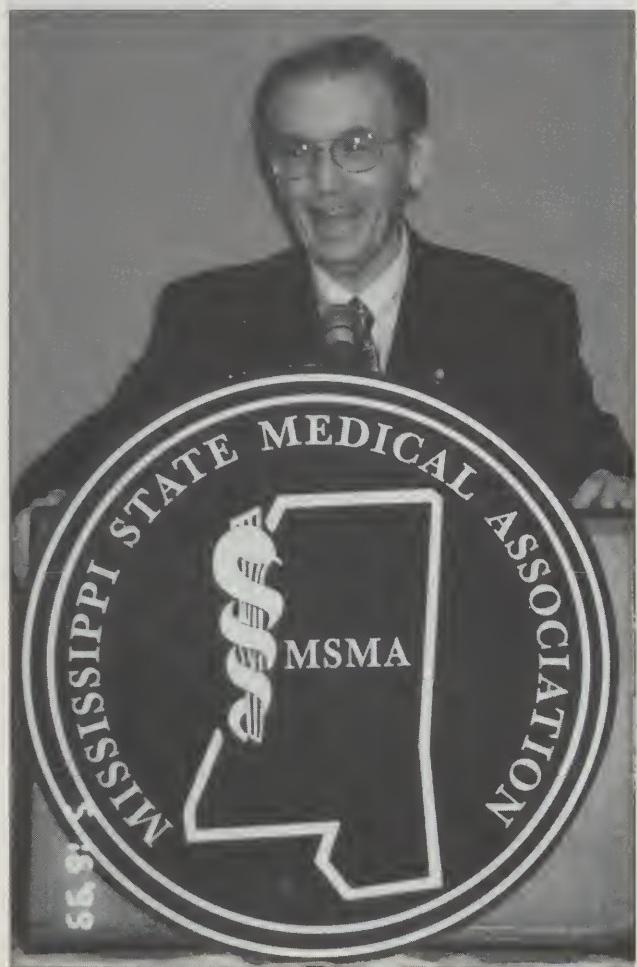
**M**r. Speaker, Members of the Board of Trustees and House of Delegates, Fellow Physicians, Alliance Members, and Guests:

I would like to thank all of you for affording me the opportunity to be your medical spokesperson as we move into the 21<sup>st</sup> century. This is indeed the highest honor that can be bestowed on one who practices medicine in this great state. I beg your indulgence as I begin by introducing and thanking a few very special people. First, the members of the West Mississippi Medical Society who convinced me to run again and helped me so much in my campaign last year. Next, all of my River Region friends and colleagues who have allowed me the opportunity to do this job, both with time off and with their financial support. You must all meet a fantastic nurse who organizes my life daily. Most of you know if you need me to do something, call Janice and rest assured it will get done.

All of the physicians in the audience know that it would be impossible to accomplish the things that we do without a family that supports and cares for us, and I, like

all of you, think mine is the greatest. Let me begin by introducing my children and grandchildren. First, my oldest daughter, Karen Hall, and her husband Reggie, a communications consultant with William Mercer Company. Many of you remember her as Miss Mississippi 1981. She has three children, Anna Kate, Travis, and Tanna. Next, my daughter Kathy, my fashion designer, who is a national recruiter for the Gap, and her husband Kerry. They have one son, Neal. Next there is Briggs III, or, as I call him, "Bubba." He is a partner in the law firm of Teller, Chaney, Hassell, and Hopson and is married to a physician's daughter, Ali. They have two sons, Briggs IV and Walt. And last there is my baby boy, Jay, who is the defensive backfield coach at Marshall University, and his wife, Michelle, who is a teacher. Last, but certainly not least, I would like to recognize my wife of over 40 years, Pat, an art major, my best friend, my greatest and fairest critic, and supporter. There is no way that I could have accomplished the things I have in medicine without her support and her love. She is the wind beneath my wings.

Now to my remarks. As Candace Keller and I were sitting at the AMA meeting in Hawaii this year, I told her



1999-2000 MSMA President W. Briggs Hopson, Jr., M.D.

that I realize the average person does not want to listen to a 30 minute speech, so hopefully my remarks will be concise and to the point. My surgical chairman once told me that when speaking one should be brief, be informative, and be gone. Hopefully I will do that. My remarks are entitled *The Mississippi State Medical Association 2000 - History Does Repeat Itself*. A hundred years ago as this association approached the final portion of the 19th century, Dr. Carroll Kendrick gave his presidential address entitled "The MSMA." I read his address and if I gave the same address today, it would still be apropos. He began by comparing Mississippi to other states--those states that were wealthier and more powerful, and he went on to say that Mississippi had accomplished much more than those states. This is so true today as we look back a hundred years. We can be proud of what we have done as we look at our accomplishments. I think everyone sitting in this room knows health care in Mississippi is one of our best kept secrets. We have accomplished much. We are a

unified medical society, we have a member on the board of trustees of the American Medical Association. We lead the nation in the percentage of physicians contributing to AMPAC. We have the strongest medical licensing board in this country. We have the best prehospital emergency care in the country. We have the first fully funded trauma care program in the United States. We accomplished the first heart transplant in the world, which was done at our University, and the list goes on and on. But as Dr. Kendrick said, "Our association has passed through the fiery ordeal and is now the pride and glory of the physicians, and should be the pride and glory of every citizen in this state. Let us profit by our experiences of the past, never go backwards, but continue to grow in numbers and strengths."

There are three things that Dr. Michael Carter alluded to earlier when he spoke to the House of Delegates that I am very interested in continuing this year as president of the Mississippi State Medical Association:

1. Involving physicians in the political process.
2. Involving young physicians in organized medicine.
3. Involving and recruitment of all physicians for MSMA.

These are also three things that Dr. Kendrick was interested in doing in 1899. Let me begin by saying one of the most pressing issues in 1899 was state and national medical legislation, so it is today. Quoting Dr. Kendrick, "There is seldom a session of the legislature that efforts are not made directly or indirectly to repeal in whole or in part the act to regulate the practice of medicine." As we look at this legislative body, we continue to see nurses, pharmacists, chiropractors, podiatrists, and many others who want to intrude themselves into our field of medicine, thus slowly chipping away at all we do. This is compounded by the HMO's and the many insurance companies and other groups who try to tell us how we should practice medicine. Although we are truly interested in being patient advocates, we fail to realize that our practice is regulated not by us but by those we elect to our legislative assembly. Dr. Kendrick challenged the physicians a hundred years ago at this time of their celebration by saying, "We must stand strong, there is no danger of vicious legislation in this state if we stand like a solid phalanx against it. Watch every bill before our legislature that affects us and write to the representatives and senators concerning it."

As Abraham Lincoln once said, "The voice of ten is mightier than the silence of 10,000." In this vein, I challenge each of you sitting in this audience to take an active part in the political process. I challenge you to help elect those who would help us. I challenge you to support those that help us, not only with your financial support but by working actively in their campaigns. Think about this. On this very day 131 years ago, one vote kept Andrew Johnson from being impeached. One vote gave Adolph Hitler control of the Nazi Party. One vote gave Oliver Cromwell control of the English Parliament. One vote change in each precinct in Illinois would have denied John Kennedy the presidency. Yes, one vote, one person, you can make a difference. I therefore challenge you all to join the American Medical Association's political action committee and the state political action committee, and encourage more physicians to run for legislative office. It is interesting to note that Dr. Kendrick served 22 years in the House and in the Senate of this state. Dr. Kendrick's statement in this vein was, "Much that the profession wants could be easily gained if physicians of the state exercised the tact and energy displayed by politicians." This is so true even today.

The second thing that Dr. Kendrick felt strongly about was obtaining new young members for the association and making those members a part of our association. He began by stating in his address, "We do not do enough to secure new members. Every member should consider himself a committee of one to try and get every regular physician in his county and in his area to join us." In this same address he also talked about the cost and the possibility of decreasing fees for young physicians and encouraging them to get involved. Many of you know that I sent a questionnaire out to the young physicians in our state approximately six months ago and asked them to fill it out. Out of approximately 500 questionnaires that I mailed, I received over 150 responses. It is interesting to note that over half of the respondents had never been to a state medical association meeting. It is also interesting that over 80% felt we should continue the scientific session. I was somewhat surprised to find that approximately half felt the meeting should not always be on the Coast but that we should think about going back to Jackson every second or third year. When I asked them about problems they wanted me to address, the number one problem brought up was managed care. Another thing brought to my attention was the fact that they felt ill prepared to run for an office in their local society or ill prepared to serve in the House of Delegates, and felt that



*Chairman of the Board of Trustees Chester W. Masterson bestows the president's pin on Dr. Hopson's lapel.*

we should have leadership meetings within the state so they could learn how to get more involved. They also were interested in learning how to lobby and deal with politicians. They were concerned about delayed payments, nurse practitioners, and apathy. One physician wrote me saying, "I agree with you, it is very discouraging to me that my contemporaries don't feel a civic duty to be involved in organized medicine. I wish I knew an answer to get more involved." Another response said, "Good luck, Dr. Hopson. I will be willing to assist in any way that you need me. My last two to three years have made me very pessimistic about organized medicine within this state." Another physician wrote, "I was extremely involved at one time. However, I don't want to just show up at a meeting and hope that it applies. With some assurance of change, I would love to participate again." I am pleased, however, to see young people such as Dan Edney and Todd Coulter participating as are many others. However, we need more.



*Dr. and Mrs. (Patricia) W. Briggs Hopson, Jr., M.D.*

I therefore challenge each of you sitting in the audience to get the young people in your organizations involved. Give them a job. Listen to them. Ask for their advice. Encourage them to get involved with the political process, to get involved socially in your community, and help them in any way you can. I will be trying this year to get more young people involved in committee activities and working in the legislative process around the state. The young are truly our future.

The third thing that I would encourage all of you to do is to continue to support the Mississippi State Medical Association. We have an excellent opportunity within the next two years to move the organization into the 21st century while doing more for our members than ever before. Our board of trustees and wonderful staff have done a fantastic job of setting new purposes, values, visions, and objectives while always being patient advocates. We have a strong organization of physicians that is only getting stronger, and I know we will be able to direct

our future when it comes to dealing with our peers around the state, thus alleviating a number of problems regarding HMO's and managed care.

Your state medical association is looking at ways it can attract physicians with new modalities. These are things we can give the physicians that they cannot get anywhere but by becoming members of the Mississippi State Medical Association, whether that be help with third party payers, additional services on the Internet, billing services, and the list goes on and on--again, new ideas, new thoughts, new things.

I stand before you holding a mirror. Sometime every day all of you look into a mirror. As you look into that mirror every day this year, ask yourself:

1. Have I been politically involved?
2. Have I helped a young physician in my area get more involved?
3. Have I become more involved in recruitment for my medical association?

I would like to close with a comment Harry Truman frequently used, "So much can be accomplished when no one cares who gets the credit." Hopefully, as we move into the new century, we can become better legislative advocates, we can get more young physicians involved, and we can get more involved with our state medical association. I look forward to working with all of you as we move into the new millennium.



*The delegation from the West Mississippi Medical Society prepares to escort the President-Elect to the rostrum. Left to right: Drs. John T. Mazzio, Lee Voulters, Briggs Hopson, Jr.; Joseph D. Austin, Randy Easterling, Chester Masterson and Joe M. Ross, Jr.*

# Activities of the 131st Annual Meeting and 95th Session of the House of Delegates

**M**SMA conducted its 131<sup>st</sup> Annual Meeting and 95<sup>th</sup> session of the House Of Delegates at the Biloxi Grand Hotel on May 14-16, 1999. Attendance increased for this year's meeting with a total of 419 registrants, including 221 physician members, 3 physician guests, 9 students and residents, 20 non-physician guests, 51 Alliance members and 115 exhibitors. This was the first Annual Meeting that was conducted under the new two and one-half day, Friday-Sunday format that was approved by the House of Delegates last year. This was also the final meeting that will be conducted at the Biloxi Grand Hotel. MSMA has contracted with the new Beau Rivage Resort in Biloxi to host the next four annual meetings beginning in the year 2000.

The educational program for this year's meeting was entitled "Medical Practice in a High Impact Society" and featured presentations on sports medicine, pain management and the regulatory oversight of

pain medicine, the essentials for a statewide trauma system, organ procurement and allocation in Mississippi, an overview of the federal emergency medical transfer laws, and an update on health legislation in the second session of the 106th Congress.

Some of the actions taken by the House of Delegates over the course of its two sessions were the following:

- Directed the Council on Constitution and Bylaws to prepare a report for next year's meeting containing the MSMA bylaw amendments necessary to grant membership to medical students and residents, and authorize a representative of both groups to serve on the association's Board of Trustees;

- Directed the Board of Trustees to continue to study and report back to the House next year on improper and excessive mark-ups by physicians of lab charges performed

by outside independent labs contrary to the Code of Medical Ethics;

- Directed the association to continue to work with the Mississippi Public Health Association on joint projects which promote quality medical and preventive care;

- Directed the Mississippi Delegation to the AMA to not support those existing and proposed policies on gun control that do not contribute to the public health and safety;

- Reaffirmed the AMA's position opposing a system of "presumed" consent for organ donation;

- Directed that the Board of Trustees work with the Mississippi State Board of Medical Licensure to determine whether state laws need to be strengthened to allow the licensure board to deal with health care fraud and abuse, and determine whether it is possible to establish a clearinghouse of information on per-

sons who exhibit inappropriate drug-seeking behavior;

- Endorsed the AMA's position that it is inappropriate and not in the hospital medical staff's best interest for an attorney to represent both the hospital and the medical staff if there are conflicts of interest which are not disclosed;

- Referred to the Board of Trustees a resolution dealing with inappropriate hospital medical staff credentialing actions by hospital governing authorities and physicians;

- Directed that the association convene one or more meetings of component society officers to determine how local medical societies might generate increased participation and best contribute to the overall objectives of MSMA.

- Authorized the association to join with the Mississippi Public Health Association in jointly raising the funds to commission a portrait of Dr. Felix Underwood for the Mississippi Hall of Fame; and

- Adopted standards of practice for physicians in collaborative practice arrangements with non-physicians via protocol.

Dr. W. Briggs Hopson, a Vicksburg general surgeon was installed as the association's President for the 1999-2000 year, while Hattiesburg anesthesiologist, Dr. Candace Keller, was elected by acclamation as president-elect. She will serve as President for the 2000-2001 association year.

In other election results, Dr. George E. Abraham, II, a Vicksburg family physician, was elected to the MSMA Board of Trustees from District 7 while Dr. Arthur M. Matthews, Jr., a Gulfport urologist, was elected to the Board from District 8.

In its organizational meeting at the conclusion of the Annual Session, the Board of Trustees elected Dr. Steve Parvin, Starkville, as its Chairman. Dr. Hugh Gamble, Greenville, was elected Vice Chairman. and Dr. Ben Carmichael, Hattiesburg, was elected Secretary. These three officers comprise the Board's Executive Committee.



MSMA President-Elect Dr. Candace Keller, President W. Briggs Hopson, Jr.; Past-President Michael H. Carter, Jr.



Dr. and Mrs. (Beth) D. Stanley Hartness  
Dr. Hartness received the 1999 MSMA Community Service Award.



1998-99 MSMA President Dr. Michael H. Carter, Jr. and 1999-2000 President Dr. Briggs Hopson, Jr. (right) present a framed resolution to former MSMA Executive Director Charles L. Mathews (left) commemorating his 26 years of service.



*Reference Committee A Chairman Dr. Steven W. Stogner of Hattiesburg visits with Central Medical Society President Dr. James R. House, III of Jackson.*

*Speaker of the House Dr. George E. McGee of Hattiesburg deserves a great deal of credit for helping make the meetings of the House of Delegates productive, interesting and efficient. Dr. McGee is known for breaking the monotony of the meeting periodically with humor, when and where appropriate. He is particularly good about maintaining control of the time so that business moves expeditiously.*



Vice-Speaker Dan Edney, M.D.; 1998-99 President Michael H. Carter, Jr., M.D.; 1999-2000 MSMA President W. Briggs Hopson, Jr., M.D. and Secretary-Treasurer Helen R. Turner, M.D.



A media training workshop was held prior to annual session for MSMA Media Spokespersons. Patricia Clark, director of media/speech training services for the American Medical Association, performs a mock interview with Dr. Ben M. Carmichael of Hattiesburg and Dr. Mary Gayle Armstrong of Jackson as part of a workshop for the members of the media spokespersons panel.

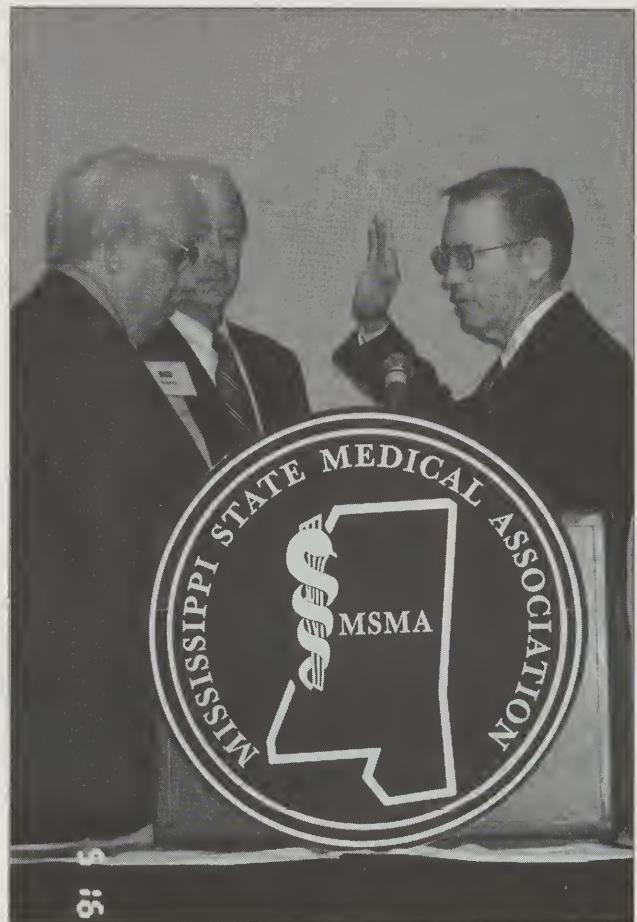


Delegates carefully mark their ballots at the opening of the second meeting of the House of Delegates. Attendance was up for this year's meeting with a total of 419 registrants, including 221 physician members, 3 physician guests, 9 students and residents, 20 non-physician guests, 51 Alliance members and 115 exhibitors.

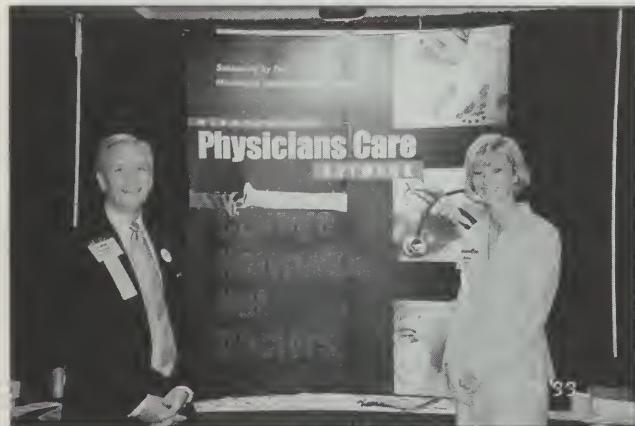




American Medical Association Board of Trustees Secretary-Treasurer Timothy T. Flaherty, M.D. addressed the House of Delegates.



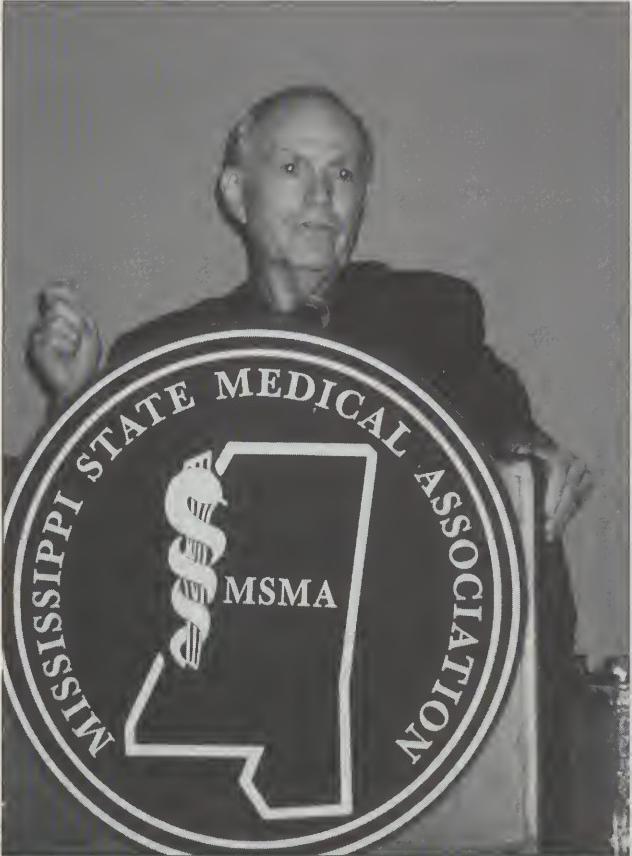
MSMA Executive Director William F. Roberts (center) holds the Bible while MSMA Chairman of the Board of Trustees Chester W. Masterson, M.D. (left) administers the oath of office of President to W. Briggs Hopson, Jr., M.D. (right).



MSMA-sponsored Mississippi Physicians Care Network (MPCN) was one of 51 exhibitors who exhibited during the three-day meeting. Shown: MPCN Chief Executive Officer Dave Streilein and Chief Contracting Officer Robie Frizzell.



The Fifty-Year Club held a breakfast on Saturday, May 15, 1999. In attendance were Drs. Ralph Brock, Frank Morgan, James R. Foster, John M. Alford, Jr.; Jim C. Barnett, Jr.; Verner S. Holmes, G.B. Flagg, Jr.; William M. Gillespie, and Frederick Tatum.



The Mississippi Organ Recovery Agency sponsored Phil H. Berry, past-president of the Texas Medical Association to speak on the need for organ donation to benefit those in need of a transplant as part of the plenary program. Dr. Berry underwent lifesaving liver transplant surgery in 1986.



Chairman of the Council on Scientific Assembly Surgical Section Bobby J. Heath, M.D. (left) of Jackson served as co-chairman of the program and is shown with American Medical Association Director of Legislative Affairs Julius Hobson. Mr. Hobson was one the speakers at the Saturday Plenary Session and provided insight on health legislation and the 106th Congress.



Ed Thompson, M.D., State Public Health Officer, Mississippi State Department of Health, gave a progress report on building a statewide trauma system in Mississippi. Frank Ehrlich, M.D., Chairman of the Department of Surgery, St. Joseph's Hospital in Patterson, New Jersey presented "Essential Components for Hospitals and Medical Staffs." Dr. Ehrlich was the James Grant Thompson Memorial Honorary Lecturer.

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# An Interview with W. Briggs Hopson, Jr., M.D. 1999-2000 MSMA President

Karen A. Evers

**B**riggs Hopson, Jr., M.D. is no stranger to hard work. Between his surgery cases and duties as president of the Street Clinic and Chief-of-Staff at ParkView Regional Medical Center, the Vicksburg physician has plenty to do. As the new president of the Mississippi State Medical Association (MSMA) he will be even busier—lobbying the State Legislature, recruiting new members, working with the Division of Medicaid, not to mention leading the establishment of a statewide trauma care system...tasks to which he brings considerable know-how and well-qualified experience.

**Tell us first something about yourself. Where were you raised?** I was born and raised in Delhi, Louisiana, a small town of about 1,500 people. There were 19 people in my graduating class and, upon graduation, I went to Ole Miss thinking of pursuing a career in either Chemical Engineering or Medicine.

**Tell me about your medical training. How and why did you get involved in medical organization activities?** After the first semester in college, I decided I really wanted to concentrate on Medicine and finished Ole Miss in three years. From there I went to the University of Tennessee and received my M.D. degree in three years. While pursuing my degree, I worked in Surgery at St. Joseph Hospital and decided that would be my field of choice. I was accepted into the residency program at the University and went on to become the chief resident and instructor in Surgery at the University. While in training, I became very active in organized medicine, serving as president of my medical school class, as chief resident, and as chief of the

candidate group for the American College of Surgeons at the University. I also attended a number of specialty society meetings with the chairman and realized it was critically important to become involved in organized medicine if you want to have a say-so in the way medicine is practiced in this country. Upon completing my residency, I moved to Vicksburg, joined the Mississippi State Medical Association, the Southeastern Surgical Congress, passed my Boards in Surgery, and became active in the American College of Surgeons at the local level. After being in Vicksburg for approximately five years, Dr. Frank Morgan and Wade Spruill approached me about becoming the Medical Director for Emergency Medical Services for the State of Mississippi. I accepted that position, one that I have now held for over 25 years. Shortly thereafter, Dr. Richard Clark convinced me that I should become Trauma Chairman for the state of Mississippi, a position in which I served with the American College of Surgeons for over 20 years. I still continue to serve the American College of Surgeons as its representative on the Prehospital Committees which deal with all paramedic training and testing. I also was active with the Mississippi State Medical Association and served as the Surgical Section Chairman for a period of two years and, at that time, the position was called Vice President of the Mississippi State Medical Association. I also served as the young surgeon representative for the American College of Surgeons within the state, as the Secretary-Treasurer for the Mississippi Chapter of the American College of Surgeons, and as President of the Mississippi Chapter of the American College of Surgeons. I fully believe what Margaret Mead once said, "Never doubt that



*Dr. and Mrs. Hopson at their daughter's (Kathy) wedding reception held in their back yard*



*Most of the Hopson family at Christmas*

a small group of thoughtful committee people can change the world. Indeed, it is the only thing that ever has." This is probably the real reason that I became involved in organized medical activities.

**What are some of your first impressions as MSMA President of both the organization and its goals?** The only group that can make a difference in the state of Mississippi with regard to medical practice is the Mississippi State Medical Association. It blends all dicta of practice with very varied personalities into one unit that has common goals. I was very pleased this year to have the opportunity as president-elect to participate in the strategic planning session that will take us well into the 21st century. I think that the core purpose, core values, envisioned future, and our objectives are things that every physician should not only read and think about but should place in his office where he can see them daily as he treats and cares for those who entrust their lives to him. The staff of the Mississippi State Medical Association who worked with the Board of Trustees did an outstanding job. I feel that the leadership at the staff level in all areas is perhaps the best of any staff within the state of Mississippi. I have asked for no information that was

not sent to me rapidly and have asked no questions that have not been answered. I hope that all physicians in the state who need information on our organization or information that will help them in the socioeconomic aspect of their practices will call the state office and get it.

I am also extremely happy that we have moved to a new office where we can carry out these functions in a more efficient manner.

**What do you see as the role of the MSMA President?** First and foremost to promote the values and ideals of the organization, to encourage young physicians to become more active in orga-

nized medicine and in the State Medical Association. To be the spokesperson for the State Medical Association throughout the state and to take issues that affect all physicians in the state to our membership and ask them for their input and advice as we, together, try to solve the problems that all of us face as we move into a new century.

I also feel that my job is to maintain a close relationship with our state legislative officials and with our legislative officials in Washington. It is only through legislative change that we can accomplish the goals we seek. As the spokesperson for medicine, I believe that my past involvement with these individuals will help me to continue to work with them as we move into the 21st century. I also feel that I have the job of educating our politicians as well as our members on medical issues that face all of us this next year.

**What do you think should be the top priorities of the MSMA?** Probably to be good listeners. We should listen to the patients and the physicians throughout the state. They alone can tell us what we need to address, the issues that concern them most, and what we can do to solve these problems. Most importantly, we should always be patient advocates. All of us hopefully got into this profession to be healers. We should encourage preventive health care. We should work to educate the public and we should look at improved treatment modalities. In this vein, encompassing all of these, we can give patients the best health care possible.

**Discuss the legislative issues of great concern to Mississippi physicians. What priority will be placed on these issues?** The number one health care issue facing Mississippians at the present time is managed care by outside groups coming into our state as well as insurance companies within our state. I feel that we must continually

be vigilant and address these issues with our legislature so that we do not lose control of the practice of medicine in Mississippi. The second greatest problem that I see is the infringement upon the practice of medicine by outside groups such as podiatrists, chiropractors, optometrists, nurse practitioners, and many others. All of these people play a role in caring for patients. However, they continue to chip away at what we do and, again, it is only through legislative action that we can keep this infringement from totally taking over patient care and taking us back to the days where charlatans practiced medicine. As always, Tort Reform will be looked at this legislative session. I am a little concerned that we will not get anything passed. However, as always, we will continue to push for Tort Reform. One of the things that will also be addressed in the coming year will be perhaps choosing a new Medicaid director. Hopefully, we will have some input with the Governor in choosing this person and it will be someone who can work with us in caring for the 20% to 25% of Mississippians who are on Medicaid.

**You were an early leader in the establishment of our current statewide trauma care system. What would you like members to know about this building process?** I think everyone in the state is aware of the fact that



*Dr. and Mrs. W. Briggs Hopson, Jr. with Governor and Mrs. (Pat) Fordice at the Governor's Mansion before the Governor's Inaugural Ball*

# William Briggs Hopson, Jr., M.D., F.A.C.S.

BORN: September 20, 1937 - Delhi, Louisiana

MARRIED: Former Patricia Spearman, Oxford, MS

CHILDREN: Karen Renee, Mary Kathryn, William Briggs, III; James Walter

OCCUPATION: General and Peripheral Vascular Surgeon, The Street Clinic and ParkView Regional Medical Center, Vicksburg, Mississippi

EDUCATION: Delhi High School, 1955.

University of Mississippi, B.S., 1958.

University of Tennessee, M.D., 1961.

Internship - City of Memphis Hospitals, 1961-62.

Residency - University of Tennessee, 1962-66.

Teaching Appointment - Instructor in Surgery and Chief Resident, University of Tennessee, 1966-67.

Clinical Associate Professor of Surgery- University of Mississippi Medical School, 1989-present.

## PROFESSIONAL SOCIETIES:

Diplomate, American Board of Surgery

Fellow, American College of Surgeons

Fellow, Southeastern Surgical Congress

American Medical Association

Mississippi State Medical Association

The West Mississippi Medical Association

American Trauma Society

Society of Clinical Vascular Surgeons

American College of Sports Medicine

National Association of Emergency Medical Physicians

Eastern Association Surgery of Trauma

American Association Surgery of Trauma

Southern Medical Association

Society of Endo Laproscopic Surgery

Society of Clinical Surgery

Harwell Wilson Surgical Society

HONORARY FRATERNITIES: Gamma Sigma Epsilon,  
Alpha Epsilon Delta

SOCIAL FRATERNITIES: Delta Kappa Epsilon,  
Phi Chi

## PROFESSIONAL ACTIVITIES:

President, The Street Clinic, Vicksburg, MS, 1980-present.

Medical Director, River Region Medical Corp., 1994-present.

Board of Directors, River Region Medical Corp., (formerly ParkView Medical Corp.), 1992-present.

Chief of Surgery, ParkView (formerly Mercy) Regional Medical Center, Vicksburg, MS, 1980-1988.

Chief of Staff, ParkView Regional Medical Center, 1988-present.

Medical Control Director, E.M.S., State of Mississippi, 1974-present.

Chairman, State Paramedic Committee, 1980-present.

Past President, West Mississippi Medical Association.

Member, Mississippi Advisory Committee, American College of Surgeons.

Member, American College of Surgeons Committee on Trauma, 1986-1996; State Chairman, 1974-89; Representative on Joint Review.

Committee for Paramedic Training, 1993-present; Representative on National Registry of E.M.T.s, 1993-present.

President, Mississippi Chapter, American College of Surgeons, 1980; Secretary-Treasurer, 1976-1978;

State Representative to A.C.S. for Young Surgeons, 1975.

Past President, Mississippi Chapter, American Trauma Society.

Founder, American Trauma Society (State).

Past President, Surgical Section Mississippi State Medical Association, 1976.

Vice-President, Mississippi State Medical Association, 1979.

Member, Board of Directors, Warren County Section, American Cancer Society.

Member, State Trauma Committee.

Medical Advisor, Governor's Highway Safety Program, 1974-1976.

Command Surgeon, 412th Engineering Command, 1967-1977.

Past President of Staff, Mercy Regional Medical Center.

Courtesy Staff, Vicksburg Medical Center.

Chairman, Ad Hoc Committee for Categorization of Emergency Rooms (C.H.P.), 1975.

State Peer Review Committee.

E.M.S. Task Force, Central Mississippi Health Planning Council.

Co-Director and Medical Consultant, Warren County Ambulance Service.

Dean's Advisory Committee, University of Mississippi Medical Center, Jackson, Mississippi, 1976-1984; Surgery Advisory Group, 1989-1996.

Chairman, Governor's Committee on Health Care, 1993.

Chairman, Q.A. Committee, E.M.S., 1994-present.

Board of Directors, M.P.C.N., 1996-present.

Chairman, Subcommittee, Physician Owned and Funded Insurance Products, 1996-1997.

Chairman, Trauma Task Force, 1997.

Member, Committee, Constitution and Bylaws, M.S.M.A., 1998.

Chairman, M.M.P.A.C. Board, 1997-present, member since 1992.

President Elect, Mississippi State Medical Association, 1998.

CIVIC AND COMMUNITY ACTIVITIES: Crawford Street United Methodist Church, Administrative Board and Sunday School Teacher.

Past President, Warren County Ole Miss Alumni Association.

Member, University of Mississippi Alumni Board of Directors, two 3-year terms.

Member, Vicksburg Chamber of Commerce; Y.M.C.A.; Vicksburg Country Club; River Town Club.

Past President, Catholic Home School Association.

Past Member, Catholic School Board.

Board of Directors, Merchants Bank, 1972-present.

Warren County Campaign Manager for U.S. Senator Thad Cochran, 1974, 1976, 1980.

Warren County Campaign Manager for Mississippi Lt. Governor Brad Dye, 1975, 1979, 1983, 1987.

President, Vicksburg Red Carpet Bowl.

Who's Who in South and Southwest.

Two Thousand Notable Americans.

Chairman, Board of Trustees, Miss Mississippi Pageant.

Team Physician, Warren Central High School, Vicksburg, 1969-present.

Board of Directors, Vicksburg/Warren Chamber of Commerce, 1991-1996.

Board of Directors, National Association of Miss America State Pageants, 1996; Chairman, Judges Committee, 1993-present.

Advisory Board, Ameristar Casino, 1997.

Multiple Sclerosis Hope Award, State of Mississippi, 1997.

over 20 years. Those of us who have worked on this were extremely happy two years ago when the legislature passed House Bill 966, signed by the governor, allowing for the development of a statewide trauma network. This year the legislature funded the program not only for development but for uncompensated care. The Trauma Care Task Force, as a subdivision of the EMS Advisory Council, has been working for the past several months on looking at the development of regions, the categorization of hospitals within the regions, and the systematic approach to trauma care within the regions. My hope is that within the next three to five years we will have the entire state molded into a network where the right patient gets to the right facility in the right amount of time to receive the right care. Only then can all of us be assured that our loved ones will be appropriately treated when they have an accident or injury. In order to do this we are going to need the cooperation of all physicians within the state of Mississippi to encourage and work with their hospitals as these regions are set up.

**The public image of physicians seems to have diminished. What would you like to see MSMA do to improve the image of MD's?** There is no doubt in my mind, looking at statistics and evaluations, that this has happened. First and foremost, we need to encourage all physicians within the state to spend more time with their patients, to listen to them, talk with them, and comfort them. We need to not only practice the science of medicine but also the art of medicine. We as physicians need to be more available and certainly more amicable toward those around us. If we could practice the four C's of medicine, our image would be tremendously improved. That is to comfort, communicate, care, and cure. It troubles me deeply when I hear physicians say they do not want to see Medicaid patients because the payment for these patients is too low. I believe these statements hurt our image with the public. It also hurts our image with our legislative body. They begin to think that we are in medicine not for people but for the dollar.

**How will Mississippi physicians benefit from your leadership?** I feel that my greatest asset as president of the Mississippi State Medical Association is my ability to communicate with our legislative body. Having chaired the Governor's Health Care Commission and the Trauma Care Task Force, I worked very closely with legislative leadership as well as our lobbyist, Charmain Thompson. I have come to know and respect a number of our legislative leaders and, in dealing with them, I feel they have grown to know and respect me also. In this vein, I hope that in the coming year we can work closely together to get

our needed issues addressed and move forward as we go into this next century. This will also be a new legislative group, as elections are this year, and I will continue to work throughout the state to encourage all physicians to become involved not only in electing people who we can work with but working with those people, once they become our legislative body.

**On a personal note, tell me about your family.**  
**How did you meet your wife, Pat?** While a student at summer school at Ole Miss a fraternity brother of mine introduced me to Pat. She lived in Oxford where her dad practiced dentistry. I soon realized that she was the only girl for me. She has been my wife now for 41 years, although I forgot to introduce her upon assuming the presidency of the Mississippi State Medical Association. We were married in 1958 and moved to Memphis where I began medical school. She studied art at Memphis State University and the Memphis Academy of Art.

We have four children. Our oldest, Karen, attended the University of Mississippi and received a degree in Speech Pathology. She was Miss Mississippi in 1981, a finalist in the Miss America Pageant, and toured the European and Pacific theaters entertaining for the Department of Defense. She worked with American Airlines as a flight attendant. She now lives in Keller, Texas, with her husband, Reggie Hall, who is a communication consultant with William Mercer and Company. They have three children, Anna Kate, Travis, and Tanna. Our second daughter, Kathy, received a Fashion Merchandising degree from the University of Mississippi and joined Macy's in Atlanta and New Orleans, and Foley's of Houston, Texas, before becoming associated the Gap where she is now an executive. She is married to Kerry Ricks, a stockbroker with Legg Mason. They live in Vicksburg with their son, Neal. Briggs, III also graduated from the University of Mississippi with a B.A. degree and jurisprudence degree. He served as student body president of the law school. He is a member of the Louisiana and Mississippi bar with a specialty in maritime law. He and his wife Ali, a dietitian and the daughter of a physician, live in Vicksburg where he is a partner in the firm of Teller, Chaney, Hassell, and Hopson. They have two sons, William Briggs IV (Liam) and Walter Quaid (Walt). Our last child, Jay, went to the University of Mississippi on an athletic scholarship where he was a four-year letterman in football and was selected to the All Southeastern Conference academic team for four years. His senior year he was listed as an academic all-American. Jay also served as president of the M Club and received the John Howard Vought award. Following gradu-



*Karen Hopson Hall with her husband, Reggie, and their children, Anna Kate, Travis and Tanna*



*Mr. and Mrs. (Michelle) Jay Hopson*



*Kathy Hopson Ricks with her husband, Kerry, and their son, Neal*



*Briggs Hopson, III with his wife, Ali, and their sons, William Briggs, IV (Liam) and Walter Quaid (Walt)*



*Dr. Hopson with one of his six grandchildren, Neal*

**How did you and your wife become so involved in the Miss Mississippi and Miss American pageants?**

When Pat and I moved to Vicksburg we realized that this was the home of the Miss Mississippi Pageant and when Pat was eligible she became a hostess for the pageant. After serving as a hostess for several years, she assumed the position of Senior Hostess and was asked to go to Atlantic City with Miss Mississippi. By that time I had served as pageant physician and was involved from that standpoint. After arriving in Atlantic City, Pat called me and said she thought I would enjoy the program, that these were my kind of people. I was rather reluctant to go. However, after talking with her over a two day span, I bought a ticket and flew to Atlantic City, and have been every year for the past 24 years. She and I also realized that Miss Mississippi had not been in the top 10 for a long period of time. We began working with Miss Mississippi and felt that in order to encourage and help the young lady, it would be wise for her to move into our home and stay with us in preparing to go to Atlantic City. The first young lady to stay with us was Mary Donnelly Haskell. The following year Cheri Brown stayed with us and she was the first young lady we had to win an award, which was a swimsuit preliminary award. The next year Cheryl Prewitt stayed with us and she went on to not only win a swimsuit award but to become Miss America. We have had some lovely, young ladies in our home preparing for Atlantic City and have been very fortunate to have had two to become Miss America. We have also had multiple preliminary winners, top ten and top five finalists. This indeed has been a joy of love. We have made friends throughout the country while dealing in pageantry. I have served on the National Association of State Pageant Board and, at the present time, chair the Judges Committee for National Association of Miss America

State Pageants. I continue to serve as CEO and president of the Miss Mississippi Program and Pat continues to serve as producer and Miss Mississippi's traveling companion to the Miss America Pageant.



*Dr. and Mrs. Hopson with Miss Mississippi 1997 Myra Barginear*



*Dr. Hopson with Carol Channing at the Southern States Party for Miss America*



*Dr. Hopson entertains Miss Mississippi contestants as Elvis.*

**Is there anything you would like members to know that I haven't asked you about?** Inclosing, I would like to say how fortunate I feel in having the opportunity to serve as president of the Mississippi State Medical Association. This honor is bestowed upon very few people and I appreciate the confidence that the physicians in the state of Mississippi have placed in me in allowing me to assume this role.

## **What They Say About Him....**

On a local level, Briggs has been a driving force behind the consolidation of health care services in Vicksburg and Warren County, Mississippi. The construction of a new hospital in Vicksburg, supported by all the physicians in Warren County, will be the culmination of decades of effort on his part.

The state of Mississippi as a whole is better off due to his insight and leadership in developing a statewide trauma system.

Dr. Hopson's election as President of MSMA represents the result of a lifetime of service addressing the health care issues of Mississippians. Those of us who have worked with him through the years salute this well-deserved recognition.

— *Randy Easterling, M.D.*

One of Dr. Hopson's greatest attributes is that he is the consummate facilitator. If there is a problem he is good about getting parties together around the table to work out their differences.

With all of the hats he wears, he is never too busy to talk with you. His door is always open.

He is a great advocate for physicians and the health of the people of Mississippi, in both his community and on the state level. He has done an awful lot to improve the status of health care for the people in Mississippi. Mississippi is very fortunate to have him.

— *Lee Voulters, M.D.*

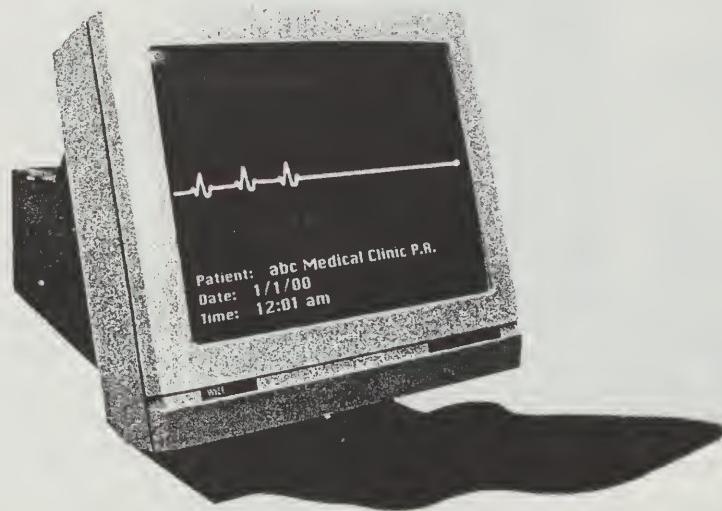
Dr. Hopson has been very involved in the community. His involvement goes beyond medicine. He has been involved in the Miss Mississippi pageant, which is a big draw for Vicksburg and he and Pat work very hard to improve it each year to keep it here. He has been instrumental in the trauma care evaluation which has materialized through legislative funding. He is extremely involved in our local hospital. This involvement beyond the surgery suite speaks highly of his character.

— *R. Lee Giffin, M.D.*

My major involvement with Briggs has been through the American College of Surgeons. For over 20 years he has been involved in trauma care through the E. M. S. advisory committee which regulates paramedics and ambulances. It is hard to measure the impact that any one physician has on health care aside from one individual patient, case by case. Briggs has had an impact on every patient in this state through his teaching of and advocacy for proper resuscitation, stabilization and transfer of trauma patients which can make all the difference in the world for a patient's lifetime prognosis.

— *Hugh A. Gamble, II, M.D.*

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# Preparing for Y2K

*[This is the third of a continuing series of excerpts  
on Y2K preparation —ED.]*

**D**ear Doctor:

In January, the Health Care Financing Administration (HCFA) wrote to you about the progress it had made in correcting problems in Medicare computer systems caused by the Year 2000 or "Y2K" problem. Many of you responded with letters and further questions. The two most frequently asked questions were: "When will HCFA be fully ready to process our claims?" and "What do we as physicians need to be doing to be ready for the Year 2000?"

We are pleased to tell you that HCFA and its Medicare contractors are fully ready to handle all appropriately formatted claims and other data exchanges on January 1, 2000. All of HCFA's internal systems have been renovated, tested, certified; and necessary changes were implemented by the government-wide Year 2000 deadline of March 31, 1999. Among other things, these internal systems operate HCFA's accounts receivable and payable operations, manage the eligibility, enrollment, and premium status of our 39 million Medicare beneficiaries, and make payments to more than 400 managed care plans on behalf of over 6 million beneficiaries. All 75 mission-critical claims processing systems operated by our Medicare contractors are also certified as compliant, including end-to-end and future-date testing. We continue to test and retest our renovated systems. We want to be sure that you get paid for the valuable work you do.

The Y2K computer problem is far more than a billing problem. We are pleased so many of you are asking the second question about what you need to do. This is a patient care and quality of care issue as well as a technical one. Our expectation is that you will continue to provide the quality of care your patients depend upon. As physicians, you will need to prepare your internal office systems to communicate with HCFA systems and prepare other aspects of your practice to continue to function reliably after January 2000. We urge you to take the following steps toward Y2K readiness. (Please see the following attachments for more details.)

- Understand the issue so that you can assure your patients of continued quality care.
- Access the numerous public and private websites offering Y2K guidance.
- Inventory your practice for other Y2K problems with the attached checklist.
- Contact your Medicare carrier now for testing of your billing submissions.
- Contact your other major third party payers and your State Medicaid Agency.
- Develop business contingency plans in the event something might go wrong.

More detail on each of these steps is attached. This is not an exhaustive list but is meant to guide you in your Y2K readiness efforts. I have also attached a Sample Provider Y2K Readiness Checklist for your information. Many of you have taken steps to prepare for Y2K and have helped us get ready for January 1, 2000, and we thank you. Please continue to let us know, through our Medicare contractors, our toll-free Y2K provider line (1-800-958-HCFA [4232]), and our website ([www.hcfa.gov/y2k](http://www.hcfa.gov/y2k)), what further HCFA activities would help you to get ready.

Sincerely,

**Nancy-Ann Min DeParle, Administrator**

**Robert A. Berenson, M.D., Director of the Center for Health Plans and Providers**

## Attachment A

# Suggested Steps Toward Y2K Readiness

### Understand the issue so that you can assure your patients of continued quality care.

Become informed about your office's readiness for the Year 2000. If any patients develop concerns in the upcoming months about how Y2K may affect the continuity of their health care, they will be greatly reassured by informed responses from you and your staff.

### Access the numerous public and private websites offering Y2K guidance.

- The Food & Drug Administration (FDA) website, [www.fda.gov/cdrh/yr2000.html](http://www.fda.gov/cdrh/yr2000.html), offers an extensive listing of the status of medical equipment readiness, by manufacturer.
- The General Services Administration (GSA) website, [www.itpolicy.gsa.gov/mks/yr2000/y2khome.htm](http://www.itpolicy.gsa.gov/mks/yr2000/y2khome.htm), offers valuable information to assess your building and infrastructure.
- The Small Business Administration (SBA) website, [www.sba.gov/financing/fry2khtml](http://www.sba.gov/financing/fry2khtml), offers information on how to obtain SBA-guaranteed bank loans that may help small, for profit providers pay for a variety of Y2K-generated needs, including: Y2K adjustments, repair, and acquisition of hardware, software, and consultants.
- Professional organizations such as your state, national and specialty medical societies and associations, and your professional liability carrier offer additional specialized Y2K information.
- Attend programs that will be provided throughout this year from HCFA, continuing medical education providers and professional organizations. HCFA sponsored programs are listed on our website, [www.hcfa.gov/y2k](http://www.hcfa.gov/y2k).
- Inventory your practice for other Y2K problems. Anything that depends on a microchip or date entry could be affected, whether it belongs to you or to an organization you depend upon. The attached checklist, which can also be found on the HCFA website ([www.hcfa.gov/y2k](http://www.hcfa.gov/y2k)), will help you in this inventory. Don't forget to:
  - Identify your mission critical items, that is, those items without which you cannot run your practice and focus on those first.
  - Contact the vendors and service contractors for your computer hardware and software, service companies such as your security company or paging system, and your medical equipment suppliers (EKG machines, for example, may actually give inaccurate diagnostic results) to obtain information regarding the Y2K status or impact on their products.
  - Update or replace systems, software programs, and devices that are not Y2K ready and that you decide are critical for your business continuity. There is no time to lose on this activity as the replacement systems you need may be back-ordered.
  - Keep notes on all your communications and testing information for possible use later and do not assume that a system or a program is Y2K ready just because someone said it is for critical items, get assurance in writing and/or attempt to have them tested.
  - The original manufacturer of a product knows the product best and is in the best position to assess the Y2K status of it and provide advice. Industry experts recommend that you not test biomedical devices until you have checked with the supplier or manufacturer to determine the advisability of such testing. Particular attention should be given to interconnected devices or systems whose components share or communicate data and that are not from a single manufacturer or source.

which can also be found on the HCFA website ([www.hcfa.gov/y2k](http://www.hcfa.gov/y2k)), will help you in this inventory. Don't forget to:

- Identify your mission critical items, that is, those items without which you cannot run your practice and focus on those first.
- Contact the vendors and service contractors for your computer hardware and software, service companies such as your security company or paging system, and your medical equipment suppliers (EKG machines, for example, may actually give inaccurate diagnostic results) to obtain information regarding the Y2K status or impact on their products.
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- The original manufacturer of a product knows the product best and is in the best position to assess the Y2K status of it and provide advice. Industry experts recommend that you not test biomedical devices until you have checked with the supplier or manufacturer to determine the advisability of such testing. Particular attention should be given to interconnected devices or systems whose components share or communicate data and that are not from a single manufacturer or source.

### Contact your Medicare contractor now for testing of your billing submissions.

- Medicare carrier and fiscal intermediary Y2K information numbers can be found on HCFA's website, [www.hcfa.gov/y2k](http://www.hcfa.gov/y2k), or can be obtained from our toll free provider information line at **1-800-958-HCFA [4232]**.
- HCFA is now requiring all Medicare contractors to *establish a test environment that will allow Medicare claim formats from providers/submitters to be validated. In some instances*, you may be able to arrange with your contractor to have "end to end" testing

done, whereby your billing submissions are tested into their system and back again to your system. *This latter form of test is only available on a limited basis, provided time and resources are available at the contractor.*

- HCFA has dedicated software that will give you a way to submit electronic claims in a compliant format in the event your system is not fully compliant. This software is available from your *Medicare contractor*.

#### Contact other major third party payers.

- The above considerations are equally applicable for transactions with your other payers. Contact them directly to arrange Y2K testing.

**Develop business contingency plans in the event something goes wrong. Focus on the things that would be most problematic for you and your patients.**

- While storing claims information on paper may be a part of your contingency, actually submitting them for payment is ill advised, as an enormous increase in paper claims cannot be accommodated by payor systems, and this could significantly delay your payments. We recommend that your billing office work with your carrier to create the appropriate electronic contingency, as noted above.

**The Health Care Financing Administration does not assume any responsibility for your Y2K compliance.**

#### Attachment B

## SAMPLE PROVIDER Y2K READINESS CHECKLIST

This checklist is intended as a supplemental guide to help you determine your Y2K readiness. Consider using this along with other diagnostic and reference tools you have obtained for this venture. The purpose of this checklist is to aid you in determining your Y2K readiness. This information is not intended to be all inclusive. The Health Care Financing Administration does not assume any responsibility for your Y2K compliance.

ITEM	Y2K READY	NOT Y2K READY
Appointment scheduling system		
Answering machines		
Bank debit/credit card expiration dates		
Banking interface		
Billing system		
Building access cards		
Clocks		
Computer hardware (list)		
Computer software (list)		
Custom applications (list)		
Diagnostic equipment (list)		
Elevators		
Fire/smoke alarm		
Indoor lighting		
Insurance/pharmacy coverage dates		
Medical devices (list)		
Membership cards		
Monitoring equipment (list)		
Office forms (claims, order, referral)		
Outdoor lighting		
Paging system		
Payroll system		
Physician referral forms		
Security system		
Telephone system		
Television/VCR		
Sprinkler system		
Treatment equipment (list)		
Safety Vaults		

# Sometimes Doctors Need Help Too—The Mississippi Recovering Physicians Program

W. Mel. Flowers, Jr., M.D.

From the Mississippi Impaired Physicians Committee  
Mississippi State Medical Association

## A BSTRACT

Fully 10 to 15% of medical doctors will develop chemical dependency during their lifetimes. This results in addiction to alcohol or other mood altering drugs. The Mississippi Recovering Physicians Program provides a confidential, non-punitive alternative to disciplinary sanctions for impaired physicians who voluntarily seek or are motivated to accept intervention, treatment, counseling, and rehabilitation for their impairment. With proper treatment, the prognosis is excellent.

### KEY WORDS:

Alcoholism  
Behavior  
Addictive Substance Related Disorders

### DEFINITIONS

“Chemical dependency” or “chemically dependent” means the state of impairment by reason of excessive use and/or abuse of alcohol, controlled substances, other drugs having addiction-forming or addiction-sus-

taining liability, or any other chemical or other substances. “Impaired physician” means a physician, resident or medical student in training or licensed to practice medicine who is chemically dependent. “Recovering Physician” means a person who, having once met the criteria of an impaired physician, has had appropriate treatment, has accepted responsibility for his/her recovery, and has engaged in those behaviors necessary to maintain sobriety.

### BACKGROUND

Not all of society understands chemical dependency as a treatable medical disease. Sometimes impaired physicians are ignored or punished, rather than treated or rehabilitated. The result is an enormous waste of human and financial resources. Fully 10 to 15% of medical doctors will develop this problem during their lifetimes.<sup>1-4</sup>

Society simply cannot afford to take this loss. When chemical dependency is considered as an illness, currently available highly effective treatment can be applied.<sup>5-9</sup> The recovering physician becomes totally abstinent, takes full responsibility for his actions, accepts and deals with the

consequences of his behavior, and returns to a fully productive life and medical practice.

It is all but impossible for this to happen unless outside help is offered and accepted. Doctors have a lot to lose and usually become highly motivated to cooperate in the recovery process. Mississippi's Caduceus Club program, in place for 20 years, returned about 750 rehabilitated medical professionals to productive careers. About 400 of these were Mississippi physicians. On the other hand, when there is isolation and lack of support, there are reports of extremely poor outcomes with high suicide rates.<sup>10</sup>

There are inherent tensions between medical licensure boards and medical societies.<sup>11</sup> The former have statutory mandates to protect the public. The latter are interested in assuring that competent physicians are allowed to practice. Both want to fully utilize medical resources without compromising patient safety. With this in mind, a Memorandum of Understanding was executed July 1, 1998, by the Mississippi State Medical Association (MSMA), the Mississippi State Board of Medical Licensure (MSBML), and the Mississippi Impaired Physicians Committee (MIPC) to establish the Mississippi Recovering Physicians Program (MRPP). The authority for this new organization was granted by the Mississippi Medical Practice Act and the Disabled Physicians Law.<sup>12</sup>

## PURPOSE AND INTENT

It is the purpose and intent of the MRPP to provide a confidential, non-punitive alternative to disciplinary sanctions for impaired physicians who voluntarily seek or are motivated to accept intervention, treatment, counseling, and rehabilitation for their impairment. The MRPP is Mississippi's impaired physicians program, and was developed in compliance with the recommendations of the Federation of State Medical Boards' Ad Hoc Committee on Physician Impairment.<sup>13</sup> The MRPP was created to provide for the identification of impaired physicians, for timely intervention, and for the implementation of appropriate measures to protect the public health and safety; to encourage and assist impaired physicians in effective rehabilitative efforts, and to ensure the continued availability of skilled, highly-trained medical professionals for the benefit of the public.

## DUTIES FUNCTIONS, AND RESPONSIBILITIES OF THE MIPC

The MIPC exercises a broad range of duties, functions and responsibilities, including, but not limited to the following: It develops, maintains, and makes available

programs that promote the early identification, intervention, treatment, and rehabilitation of physicians who may be impaired by reason of chemical dependency. It operates a Recovering Physicians Help Line, where information and assistance for impaired physicians can be obtained. It serves in a consultant and advisory capacity to the MSBML and the MSMA. It receives, evaluates, and investigates reports of suspected impairment from any source including referrals from the MSBML, physicians, hospital administrations, family members, and others. It intervenes in cases of suspected impairment and refers impaired physicians for appropriate evaluation and treatment to a MSBML approved facility. It establishes a treatment contract with each impaired physician, detailing the requirements of his/her recovery program. It monitors the treatment and rehabilitation of impaired physicians, and provides post-treatment monitoring, aftercare, and advocacy for the recovering physician. It renders quarterly reports to the MSBML on the status of MRPP program participants. Self-referred physicians are identified by code (number), are not reported to the National Practitioners Data Bank, and do not lose their DEA privileges. The MIPC reports to the MSBML any physician it has reason to believe may be impaired and, (1) who has failed or refused to follow the recommendations of the MIPC for treatment and/or rehabilitation, or (2) who has discontinued such treatment and/or rehabilitation against medical advice, (3) who has failed to abide by the terms and conditions of an aftercare contract with the MIPC, or (4) who, in the opinion of the MIPC, is unable to continue in the practice of medicine or osteopathy with reasonable skill and safety to patients. It works with the MSBML to develop standards for the ongoing evaluation of treatment facilities utilized by the MIPC. It makes recommendations for continuing medical education (CME) in the areas of physician impairment.

The MIPC develops outreach and awareness programs which seek to educate both the general public and the medical community concerning the disease of addiction and the services available through the MRPP. MIPC maintains a program description containing the operational details of the MRPP, including available treatment and rehabilitation resources, drafts aftercare contracts, and develops monitoring procedures.

## CONFIDENTIALITY

All information, files or records maintained by the MIPC, or any of its members, attorneys, staff, or employees is maintained in the strictest confidence and is not disclosed to any individual, organization or entity unless, (1) it is essential to disclose such information to further

intervention, treatment, counseling or rehabilitation needs of the individual physician concerned, and then only to those persons or organizations who need to know, or (2) unless its release is authorized in writing by the physician, or (3) unless the MIPC is required to render a report to the MSBML. Unless otherwise required by law, any confidential patient information and other non-public information acquired, created, or used in good faith by MRPP, the MSBML, or MSMA is confidential and is not subject to discovery or subpoena in a civil case.

## **COMPOSITION OF THE MISSISSIPPI IMPAIRED PHYSICIANS COMMITTEE**

The MRPP operates under the supervision and direction of the MIPC, a committee of physicians licensed to practice medicine in Mississippi who are selected and appointed in the following manner: The Medical Director is a salaried, full time physician selected and approved by the MSMA Board of Trustees who coordinates and directs the activities of MIPC and MRPP. The Executive Director is a paid employee of the MIPC, and reports to the MIPC Chairman and the Medical Director. The Executive Director is responsible for the books and records of the organization, and supervises the day-by-day activities of the MIPC office, and serves as Executive Director of Caduceus. The MIPC Chairman is a physician selected and approved by the MSMA Board of Trustees who serves as chairman of the MIPC and assists the Medical Director with the administrative and operational aspects of the program. The MIPC Chairman and Medical Director name at least five and not more than seven physicians qualified because of their knowledge and/or expertise in the area of chemical dependency to serve as members of the MIPC. MIPC members are members of the MSMA and are presented to the MSMA Board of Trustees for confirmation. MSMA submits the MIPC membership to be confirmed by the MSBML. The MIPC chairman and members serve for a period of three years and are eligible for reappointment. MIPC members, including the chairman, serve on a voluntary basis and receive no compensation.

## **FUNDING**

To the extent authorized by law, funding for the MIPC and the MRPP is provided in part by the MSBML. A surcharge is added to the yearly licensure fee for health providers licensed to practice medicine in Mississippi and is used to fund the MIPC and MRPP. Other funds are provided by MSMA and by participant fees. The MIPC explores all avenues to develop further funding to support its activities. MIPC funds are utilized to support the

chemical dependency programs for health providers licensed by MSBML and the MIPC provides a copy of its annual independent audit to both the MSBML and MSMA.

## **CADUCEUS**

The Caduceus Club of Mississippi, originally initiated in 1978, was the name given to the former physicians recovery program which served as the aftercare monitoring and advocacy program for the past 20 years. Now the Caduceus name has been applied to the present support organization for the MRPP. It consists of several regional groups who meet on a weekly basis to share experience, strength, and hope with each other so they may solve their common problems and recover from chemical dependency. Caduceus is the backbone of the Recovering Physicians Program, and assists the MRPP in its role as monitor and advocate. Caduceus holds an annual, family oriented week-end retreat for its members and alumni which is part of the recovery contract. The agendas include business meetings of the membership with the MIPC, educational sessions relating to chemical dependency, meetings of Alcoholics Anonymous and Alanon, and periods of fellowship, rest, and relaxation for the physicians and their families. Caduceus is administered by the MIPC.

Any impaired or recovering health care professional or student (physician, podiatrist, osteopath, dentist, veterinarian, or nurse) may become a member of Caduceus. He or she must apply for membership, must be currently in treatment for chemical dependency or have successfully completed a treatment program acceptable to the MIPC, and must be approved for membership by the MIPC.

## **AFTERCARE MONITORING**

Impaired physicians completing any indicated treatment are carefully monitored through at least a five-year contract with the MRPP with the active oversight of the MIPC and its Medical Director. Such monitoring includes weekly local Caduceus meeting attendance, regular reports to the MIPC by the recovering physician's local MIPC facilitator, periodic personal appearances before the MIPC, routine Alcoholics Anonymous or Narcotics Anonymous and/or other self-help meeting attendance, and other activities determined by the MIPC.

## **CONCLUSIONS**

Effective treatment is available for doctors who have alcoholism or drug addiction. The Mississippi Recovering Physicians Program provides a confidential, non-punitive alternative to disciplinary sanctions for

impaired physicians who voluntarily seek or are motivated to accept intervention, treatment, counseling, and rehabilitation for their impairment. The doctor who realizes that he has a problem can turn to this organization without jeopardizing his/her medical career. The doctor's family can get help without the disastrous financial consequences of a lost livelihood. The colleague can obtain help and thereby save a precious life without destroying his friend's ability to practice medicine.

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**W. Briggs Hopson, Jr., M.D.  
The President's Page**

## **New Buildings, New Purpose, New Values, New Objectives, New Future**

**A**s we approach the turn of the 20th century, your Mississippi State Medical Association begins with a total new freshness. First, we have a new location and a new building—we moved in the week following the State Medical Association meeting in Biloxi. Moving is always difficult, but it is a renewal as you have the opportunity to clear out your desk and update some files. Our new building is located at 408 West Parkway Place, just off Highland Colony Parkway in Ridgeland, Mississippi. We will be dedicating this beautiful new facility on August 13, 1999. We are asking all members and their families to join us in this celebration from 3-5 p.m. This new facility will be easier to get to, give us more working space, and house all of our operations along with those of MPCN, MSMA Benefit Plan and Trust, and Mississippi Physicians Insurance Company. This gets us to the right place at the right time. However, all of us know that buildings do not make organizations work. They are only the shell in which business takes place. In this vein, your Board of Trustees met in a strategic planning session in March of this year. At that time this group, along with our fantastic staff, worked to develop and write the following new strategic plan which should take us well into the 21st century. The plan as adopted by your house of delegates is as follows:

### **CORE PURPOSE**

To advance the ethical practice of medicine and ensure high quality, physician-directed patient care.

### **CORE VALUES**

Ethics, integrity and professionalism are essential elements of good medical practice.

Physician advocacy grounded in fairness and compassion is good for patient care.

Physicians should provide leadership in all matters affecting health care.

The physician-patient relationship is the cornerstone of our health care system.

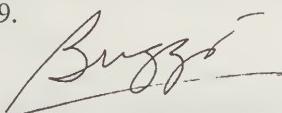
#### ENVISIONED FUTURE

To be an essential part of every Mississippi physicians's professional life.

#### OBJECTIVES

1. Be an aggressive and effective public and private sector advocate for physicians.
2. Provide the health care and medical practice information, products and services that will enable physicians to be successful in their chosen mode of practice while rendering the best possible care for their patients.
3. Establish the health care delivery and service support systems that will empower physicians to provide the most appropriate care for their patients.
4. Educate and inform the public about the importance of physician control and direction of their individual health care needs.

I would like for each of you to cut this list out and post it in an area of your office where you and your staff will see it each day. Although I think the entire document is worth reading if you read and remember nothing else, I ask you to note: "**THE PHYSICIAN-PATIENT RELATIONSHIP IS THE CORNERSTONE OF OUR HEALTH CARE SYSTEM.**" If we remember this and treat patients as we would like to be treated, then medicine will be vibrant, visible, and viable in the year 2099.



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*followed by an*

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*on Friday the 13th of August, 1999*

*from 3 p.m. until 6 p.m.*

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# Editorials

JOURNAL OF THE  
MISSISSIPPI STATE MEDICAL ASSOCIATION  
VOLUME XXXX, NUMBER 7  
JULY 1999

## THE SACRAMENT OF INVITATION

At the recent MSMA Annual Session, our incoming president, W. Briggs Hopson, MD, of Vicksburg, quoted Dr. Carroll Kendrick, an Alcorn County physician who served as president of this organization from 1898-99. Hopson stated that at the session one hundred years ago, Kendrick encouraged the association's physicians to become "committees of one" to recruit new and diversified membership. This charge is inherent in our Hippocratic Oath. Sentences after we swear by Apollo, we promise to look upon physicians and their offspring "in the same footing as my own brothers." Hippocrates saw medicine as an "Art" and its practitioners as "disciples." In this capacity, we have responsibilities to our professional peers, and important among those responsibilities is the one Kendrick mentioned: to encourage interest and involvement by our brothers in our association, Mississippi medicine's best hope for physicians.

Historically left out of our association were the young, women, and African Americans. The organization has done a very good job in getting younger members involved. One physician told me that the number of young people involved in the Mississippi association was more noticeable than at any other state association meeting he had attended. The strides physician women have made in our organization is also significant, as testified by the election this year by acclamation our new president-elect, Candace Keller, MD, of Hattiesburg, who will make history as the first female president of our state association. And state membership was up last year, from 3,294 members in 1997 to 3,376 in 1998. This certainly bodes well for our association.

There is one group we have not succeeded in recruiting as well: our African American peers. They constitute an increasingly large percentage of our state's physician force and represent only a minimal percentage of our association's membership. I shared an interesting conversation on this topic at the Annual Session with H. Todd Coulter, MD, a Pascagoula physician. Todd is active in the state and national association, serving as a leader in the AMA Young Physicians Section. He also happens to be African American. He noted that because of segregation and racism in the past, there was a separate black medical association, The National Medical Association. Its role is still important, but Coulter sees the strong need for black physician involvement in both the MSMA and the AMA.

How to do it? It remains remarkably similar to the problem of recruitment Dr. Kendrick faced one hundred years ago. It still involves "committees of one." Todd called this individual recruitment the "sacrament of invitation." He describes this sacred activity as reaching out to other physicians, one on one, and "inviting the uninvited." He noted that he got involved first at the local society level, and he did this after a personal invitation from other doctors.

The best place of activity of these "committees of one" is at the local level. Coulter advised establishing relationships with other physicians on a personal level and encouraging their activity in our local societies. This sentiment was echoed by George E. McGee, MD, of Hattiesburg, our very competent speaker of the House of Delegates. He commented at the recent session that "we need to reinvigorate our county societies." He called for diversity in the organization's membership and concluded, "Our local county societies should be strong, vibrant." He also proposed a series of meetings of county society officers to foster ways to reinvigorate the association's vitality at the local level. These are wise words and should help the association in its efforts to represent the Mississippi physician, be he or she white or black or male or female or young or old.

So we see what we have to do. We see where that battle is to be waged. It will not be best accomplished by broad statutes or resolutions, but rather by the resolve of individual members, extending the sacrament of invitation one on one to our peers and inviting the uninvited.

— *Lucius Lampton, MD*  
*Associate Editor*

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

## Women's Life Conference Another Success



*Nancy Leader, Delta Burke and Pam Welsh*

When I was asked to write an article on the Women's Life Conference, my first thought was "now that, I know about!" After all, I had been a Medical Alliance booth volunteer my first year in Mississippi, the alliance representative for the Women's Health Issues committee for two years and for the past three years, I have participated by organizing and manning The Heart Care Center(my husband's cardiology practice in Laurel), booth at the conference.

In 1995, my first year to participate, I witnessed a well-organized, unusual event take place. A sisterhood of women came together to learn about those things which affect a woman's life. Each year that sisterhood is evident. New friendships are formed and old friendships are renewed. This year, my fifth year to attend, I noticed many of the participants knew me. They knew that I was going to be there and they said, "back again?" "Back again" is the spirit of kinship that flows throughout the annual Women's Life Conference.

The conference is usually held on the last Saturday each April. For the past four years Jones Junior College in Ellisville, Mississippi has hosted the day-long event. The conference activities include an excellent continental breakfast, a health and wellness information booth fair, a general session with a nationally recognized motivational speaker, your choice of one of four health/wellness forums comprised of local professionals, and one of seven concurrent educational sessions on topics ranging from the latest health information to business and finance. In between, there are lots of goodies, Special classical entertainment accompanies the fabulous lunch and many wonderful door prizes are drawn at this time. The day concludes with the keynote presentation by an internationally recognized celebrity,

On the subject of keynote speakers, just read the following list of speakers from the first conference in 1990 to the tenth anniversary this year and I think you will understand why this event is so popular: Dr. Joyce Broth-

ers-1990, Mary Ann Mobley-1991, Linda Dano-1992, Dr. Sonya Friedman-1993, Ann Jillian-1994, Naomi Judd-1995, Suzanne Somers-1996, Joan Rivers-1997, Vicki Lawrence-1998 and Delta Burke-1999!

They spoke on the issues that most affected their lives, such as health problems or relationships, or they talked about their lives and how they came to be who they are now. The keynote presentation also includes a lengthy question and answer period, which provides for a more intimate relationship between the celebrity and the audience.

Another very special feature of this conference is the sponsor's luncheon. Two representatives from each of the sponsoring organizations are invited to attend a private luncheon with the keynote address speaker. As the Jones County Medical Alliance representative, I have had the honor of attending two of these luncheons, one with Vicki Lawrence and one with Delta Burke, both of whom were so gracious and friendly.

This year, the tenth anniversary of the Women's Life Conference was especially meaningful to the many people who have worked year round on the event. Karen Vanderslice, RN, BSN, Coordinator of Community Education for South Central Regional Medical Center, explains, "It's a great service to the community. Our topics range from health services and information to business and finance. We present the most up-to-date information. We really listen to the needs of the participants and try to fill that need each year by providing information on anything that could ultimately affect a woman's health."

The leadership behind the Women's Life Conference is the Women's Health Issues Committee. The committee was formed in 1989 and consists of four South Central Regional Medical Center staff members and thirteen community leaders who volunteer their services.

The committee meets regularly to discuss current health care issues and to plan the Women's Life Conference. The vice-president of the Jones County Medical Alliance serves on this committee. As the conference date approaches, the committee draws upon the resources of the alliance to assist where needed. In the past, Jones County Medical Alliance members have introduced conference speakers and were in charge of the opening speaker's and keynote speakers' booths. At these booths, speakers provide copies of their books or motivational audiotapes and videotapes for purchase and the medical alliance members are needed to handle those transactions. We are frequently called upon to "man the booth." The alliance is also responsible for requesting and collecting the nearly 100 door prizes that are donated each year.

Past door prizes have included: antiques, vacations

for two, televisions and a fabulous diamond ring. "We are very fortunate to have such generous area artists and merchants," says Karen Vanderslice. "Each business donor also benefits when their business and donation is included on the door prize list, which is given to each participant, and this year's attendance was over 900."

The focus of the Jones County Medical Alliance sponsor booth is different each year. In the past, we have focused primarily on breast cancer awareness by providing complimentary breast self-examination shower cards and other written information. A breast model was made available for demonstration of correct breast self-examination (BSE) technique. The breast model contained several palpable lumps.

This year the alliance booth featured complimentary copies of low-fat or low-cholesterol recipes. The recipes were provided by the alliance members and included well-known recipes and secret family favorites. More than 3,000 copies were distributed to those attending this year's event. The booth fair is definitely a favorite with the participants. "It's where all of the free stuff can be found. All medical clinics of physicians on staff at South Central Regional Medical Center are provided complimentary booth space at the conference. It's a good way to introduce new physicians, new procedures and the medical advances available in our area," says Karen Vanderslice.

In order to make this event affordable for all women, the conference fee is kept to a minimum. The low conference fee has been possible due to the generosity of several corporate and organizational sponsors. This year's sponsors were: South Central Regional Medical Center, WDAM-TV, Pinebelt Country B-95 radio, Eli Lilly and Company, Jones Junior College, Community Bank, South Central Mississippi Cancer Center, American Cancer Society, Jones County Medical Supplies/Quinn Pharmacy, Pfizer, and Jones County Medical Alliance.

Enough good things cannot be said about the Women's Life Conference. My friend, Brandie McAndrews, attends the conference every year with her mother, who drives over from Dallas. She states, "You are in by 8:00 and out by 3:00. There is so much information available, the doctors answer your specific questions and the booth fair is great. Where else can you get all of that for only \$20. My mom and I have the best time... and we were this close to Delta Burke."

At the conclusion of each conference, each participant receives a special autographed conference print. The seashell was chosen to be the delicate and enduring symbol of this conference. I have four of these prints in my home and I hope to add to that number each year as the tradition of the Women's Life Conference continues.

## Information and Quality Health Care



The State Medical Association convention offered a forum for discussion of the Cooperative Actions For Health Program (CAHP) project topic, "Control of Diabetes—A Family Disease." From the left are Dr. Al Rausa, district health officer of the Delta Hills Public Health District III, State Department of Health; Dr. Karen Peters, director of CAHP with the American Medical Association in Chicago; Dr. Beth Drabant, CAHP director for the American Public Health Association, Washington, D. C.; and Louisa Denson, president of the Mississippi Public Health Association. Dr. Peters and Dr. Drabant, in presenting the history of medicine and public health, demonstrated the value of the CAHP grant through the Robert Wood Johnson Foundation for building, supporting and strengthening collaboration to improve health in the state. Information and Quality Healthcare is working with the State Medical Association and the Mississippi Public Health Association on the CAHP efforts, with Susan McMillan serving as state coordinator.

With an outstanding slate of potential board members to serve on the I.Q.H. board of directors, the outcome of this year's election was assured: those elected to new terms would fulfil the duties of interested, contributing members dedicated to the support and growth of the organization.

All the physician members who were willing to be placed on the 1999 spring ballot are appreciated.

The election results: Dr. Stanley Hartness of Kosciusko; Dr. Eric McVey of Jackson; Dr. Malcolm Taylor of Jackson; Dr. George Abraham of Vicksburg; Dr. Jack Evans of Laurel; Dr. John Paul Lee of Forest; Dr. Mary Gayle Armstrong of Madison; Dr. Braxter Irby of Brookhaven. Dr. McVey's specialty is infectious diseases; Dr. Taylor is a cardiologist; and Dr. Hartness and Dr. Abraham are in family practice. Dr. Armstrong, Dr.

Evans and Dr. Lee are all family practitioners. Dr. Irby is a cardiologist.

Retiring from the board are: Dr. John Hassell of Laurel; Dr. Eugene Webb of Greenville; Dr. Tom Fenter and Dr. Joe Files, both of Jackson.

Delbert Oliver of Jackson has been named to serve as consumer representative on the 21-member board, 18 of whom are physicians. Two hospital representatives on the board include John Dawson of North Mississippi Medical Center in Tupelo, and William Oliver of Forrest General Hospital in Hattiesburg.

Physicians with terms expiring next year include Drs. Leonard Brandon, Starkville; Charles Brock, Cleveland; John Cook, Jackson; Richard deShazo, Jackson; Leslie England, Natchez; Rodney Frothingham, Greenville; Tom Jeffcoat, McComb; John Patterson,

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Pontotoc; Glenn Peters, Louisville; and Kenneth Reid, Meridian.

The board convened in May, for the first meeting in the new I.Q.H. offices. Proceedings included an official ribbon-cutting ceremony representing the move to 385 Highland Colony Parkway in Ridgeland, coordinated by the Metro Jackson Chamber of Commerce. I.Q.H. staff members have successfully moved into the new offices; the Quality Forum for 1999 has been presented at the University Club in Jackson, and the year's quality award recipients and the Derrick Award recipient have been announced. In July, three regional programs will be presented in preparation for the Sixth Scope of Work which begins in August. The dates and sites include: July 21, Gulfport, Orange Grove Community Center; July 27, Jackson Medical Mall; July 29, Grenada, Holiday Inn.

Work continues on the Cooperative Actions for Health Program (CAHP), a collaborative grant program among the Mississippi State Health Association, the State Medical Association, and I.Q.H. A presentation at the State Medical Association meeting in May featured guest speakers and attracted numerous interested physicians. The grant for building, supporting, and strengthening state and local collaboration between medical and public health professionals to improve the public's health is focusing on diabetes in the state.

#### **Derrick Award to Dr. Gordon**

The annual A. A. Derrick Outstanding Physician Award has been presented to Dr. David Lee Gordon, who is associate professor in the Department of Neurology at the University of Mississippi Medical Center in Jackson. The award is made in memory of the late Dr. Arthur Derrick of Durant, a longtime supporter of the Peer Review Organization (PRO) and quality health care.

Dr. Gordon has been with UMC since 1991. The Chicago native, in his outstanding work in the stroke screening program throughout the state, emphasizes the importance of continuously improving the quality of care in the state, as well as the PRO's contribution to the program. He studied at Duke University in North Carolina and the University of Miami School of Medicine, where he graduated in 1985. Postdoctoral training included St. Luke's - Roosevelt Hospital Center in New York, internship in internal medicine; Mt. Sinai Medical Center in New York and the University of Iowa Hospitals and Clinics. His certifications include the National Board of Medical Examiners and the American Board of Psychiatry and Neurology. Professional affiliations include AMA, American Academy of Neurology, National Stroke Association and the American Heart Association, Fellow of the Stroke Council. Dr. Gordon has published many papers, chapters, books and reviews and makes personal and media presentations on the subject of stroke throughout the country.

#### **Quality Award Recipients for 1999:**

Award of Excellence for the facility participating in multiple projects and demonstrating the greatest improvement in more than one indicator in each of the projects: **North Mississippi Medical Center, Tupelo.**

Spirit of Continuous Quality Improvement Award for the facility who has participated in multiple projects since the initiation of the Health Care Quality Improvement Program and has demonstrated an exemplary level of continuous quality improvement in each of the projects: **Baptist Memorial Hospital-Golden Triangle, Columbus.**

Special Recognition Award, presented to the facility participating in multiple projects and demonstrating the greatest improvement in at least one of the projects: **Biloxi Regional Medical Center, Biloxi.**

Award of Merit, presented to facilities participating in multiple projects and achieving a high level of improvement in at least one of the projects:

**Gulf Coast Medical Center, Biloxi**, for achievements in the Community Acquired Pneumonia Project;

**Webster Health Services, Eupora**, for achievement in the Emergency Room-Acute Myocardial Infarction Project.

—*James S. McIlwain, M.D., President*

## Personals

**Joe C. Files, M.D.**, professor of medicine, director of the division of hematology and associate chairman of the department and **Daniel W. Jones, M.D.**, professor of medicine, director of the division of hypertension and the department's vice chairman for primary care at the University of Mississippi Medical Center (UMC) were honored by the esteemed Southern Society for Clinical Investigation. Membership recognizes academic physicians who have made significant contributions to clinical research.

**William B. Geissler, M.D.**, associate professor of orthopedic surgery, division of hand/upper extremity surgery, chief of arthroscopic surgery and sports medicine at the University Medical Center, was recently invited to be an international participant in the "Les Fractures du Quart Inferieur du Radius et Leurs Sequelles" symposium in Paris, France. Dr. Geissler spoke on arthroscopic management of intraarticular distal radius fractures. He also was a panel participant on arthroscopic management of carpal instability and tears of the triangular fibrocartilage complex associated with distal radius fractures.

**Charles N. Crenshaw, III, M.D.**, was recently named a Fellow of the American Academy of Family Physicians. Dr. Crenshaw is a family practice physician affiliated with the Grant's Ferry Family Medicine Clinic which is part of the Preferred Medical Network. Dr. Crenshaw graduated with distinction, Phi Kappa Phi, from the

University of Mississippi in 1975 with a Bachelor of Science degree in Biology. He received his medical degree from the University of Mississippi in 1980. He completed one year of a family practice residency at St. Francis Hospital in Memphis, Tennessee in 1981. Dr. Crenshaw is a member of the Mississippi Academy of Family Physicians and the American Academy of Family Physicians. In 1998, he served as chairman of the Pharmacy and Therapeutic Committee and as past chairman of the Medical Records Committee. While practicing at Newton Hospital and Rush Hospital in Newton, Mississippi, Dr. Crenshaw served as past chief of staff, past vice-chief of staff, chairman of the Emergency Room committee and medical director of the Newton Ambulance Service.

**Allen Gersh, M. D.**, Hattiesburg nephrologist, was elected by the Mississippi State Board of Health to succeed Lloyd Rose, D.D.S., as chairman. Dr. Gersh is affiliated with Hattiesburg Clinic, P.A., and is medical director of the Hattiesburg Clinic Dialysis Units and a member of the clinic's board of directors. He has been a member of the Board of Health since 1996. Dr. Gersh attained his medical degree from the University of Illinois and was awarded a research fellowship at the University of Washington Department of Preventative Medicine. He interned at Deaconess Hospital, Buffalo, New York, and served his medical residency at Tripler Army Medical Center, Honolulu. He received a nephrology fellowship at Brooke Army Medical Center in

San Antonio. He is past president of the Mississippi State Nephrologic Society and former vice president of the National Dialysis Association. He served as chairman of the Legislative Council of the Mississippi State Medical Association and was chairman of the Department of Medicine at Forrest General Hospital in 1993.

**Larry D. Field, M.D.** recently served as a Faculty Member at the Arthroscopy Association of North American Meeting in Vancouver, B.C. At the meeting he presented a talk entitled "The Arthroscopic Management of Elbow Contracture."

**Charles A. Hollingshead, M.D.** was named medical director of the recently expanded Preferred Medical Network clinic system. At present, there are twenty-two physicians and two nurse practitioners providing care in the network's fourteen practice sites. This summer, two additional clinics and five physicians will join the system. Dr. Hollingshead is a board certified family practice physician practicing at East River Medical Clinic. He has accumulated 32 years of experience as a family practitioner. He is a certified medical review officer, and is also a certified instructor of Advanced Cardiac Life Support Training. He received his medical degree from the University of Mississippi School of Medicine.

**Edward E. Rigdon, M.D.** was appointed to serve as Chairman of the The Southeastern Surgical Congress Gold Medal Committee. His responsibilities will include as-

sisting with planning the program for the 68th Annual Scientific Meeting that will be held at the Wyndham Palace Resort and Spa, Lake Buena Vista, Florida, February 5-8, 2000. Dr. Rigdon is an Associate Professor of Surgery at the University of Mississippi School of Medicine. The Congress represents over 3,000 general surgeons in the southeast and the territories of Puerto Rico and the District of Columbia. Dr. Rigdon earned his undergraduate degree from Mississippi State and his medical degree from the University of Mississippi School of Medicine. He served an internship at the University of Alabama, in Birmingham, Alabama, and a residency at the University of Mississippi School of Medicine. He is Board Certified by the American Board of Surgery.

**Jack B. Foster, M.D.**, a board-certified cardiologist in private practice with Cardiology Associates of North Mississippi, P.A., recently completed certification requirements for additional qualification in nuclear cardiology.

**John W. Gaudet, M.D., F.A.A.P.**, formerly of Hubsouth Medical Group, is now practicing pediatric medicine with Children's Medical Group of Hattiesburg.

**Augustus P. Soriano, M.D., F.I.C.S.** has reaffiliated with Laird Hospital in Union after having practiced with Neshoba County General Hospital.

**Todd L. Fulcher, M.D.**, board certified in family medicine and member of the Blue Cross Key Physician Network and Mississippi

Health Partners, has joined the Baptist Medical Clinic.

**Robert E. Coghlan, M.D.** will close his medical practice at the Family Practice Clinic in Aberdeen effective July 31, 1999.

**F. Lee Horn, M.D.** has opened a new office, Family Medical Clinic of Vardamen, located at 416 East Sweet Potato Street.

**Melvin R. Holman, M.D.** of Columbus has retired from the practice of obstetrics and gynecology.

**Robert E. Trotter, M.D.**, of the Physicians & Surgeons Clinic in Amory, has retired from the practice of obstetrics and gynecology.

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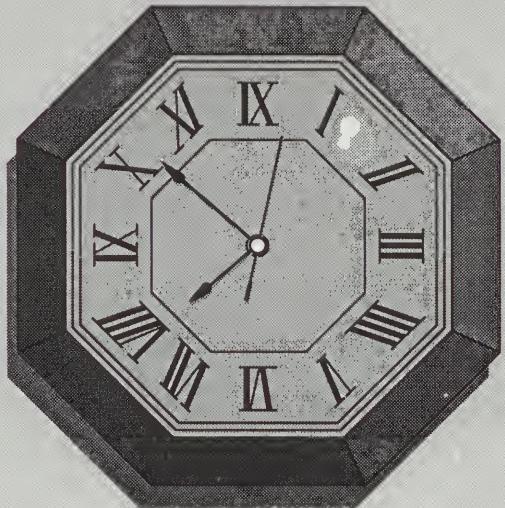
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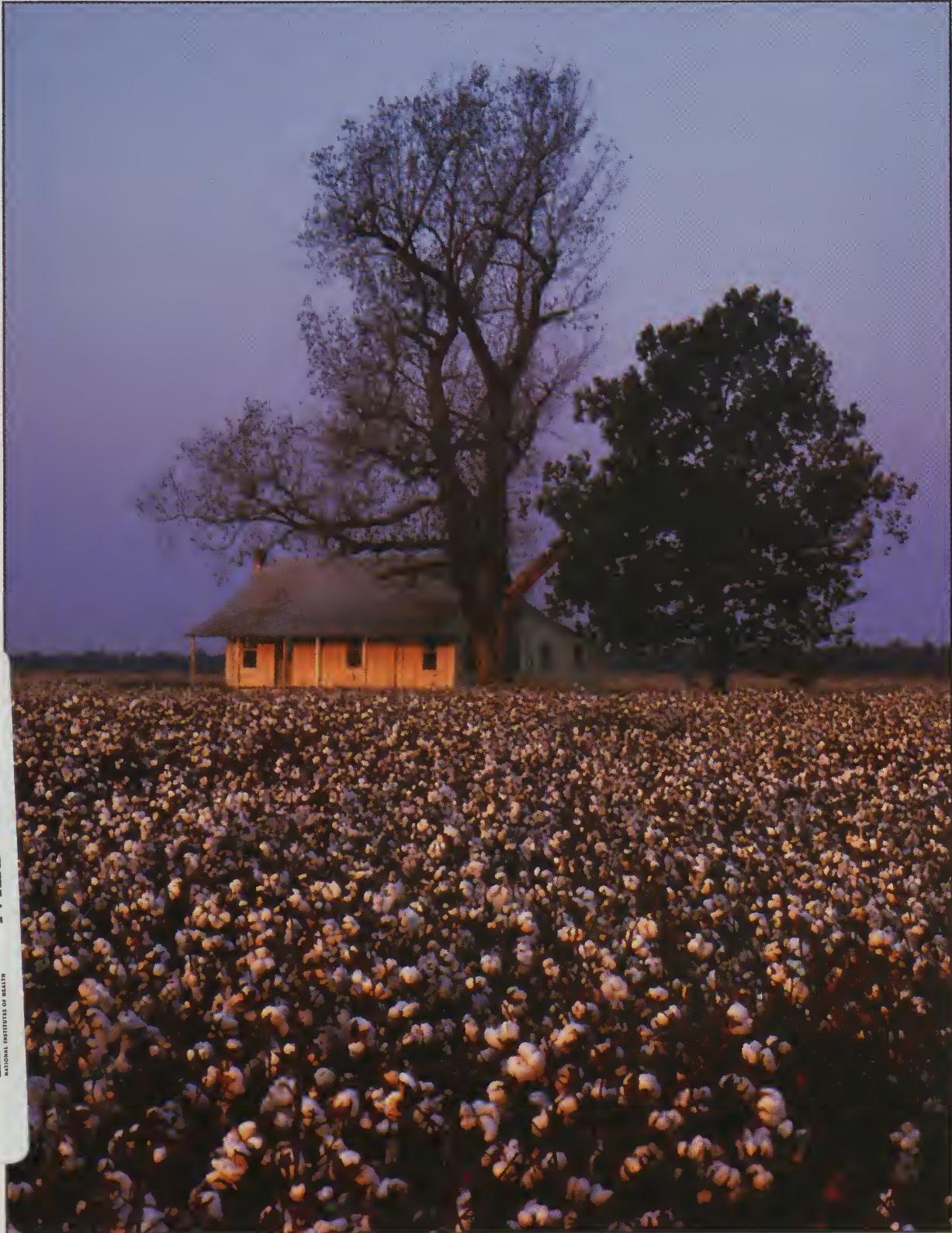
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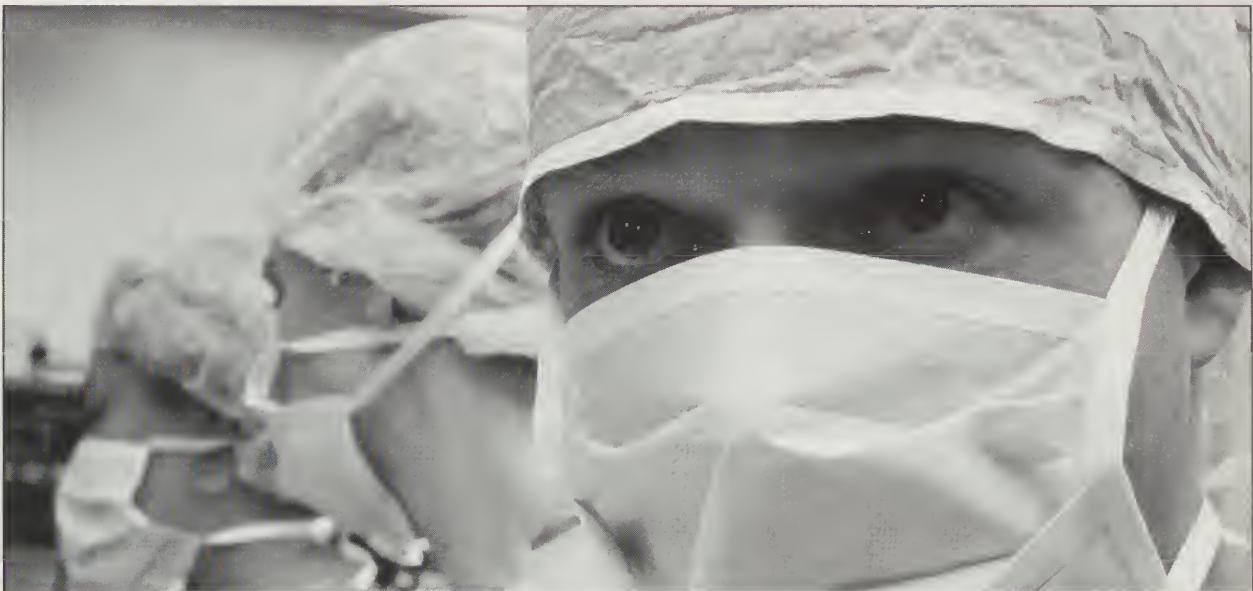
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**Cover photo:** R. C., "Corky" Sneed, M.D., Pediatrician and Physical Medicine and Rehabilitation Specialist, is the Medical Director of Children's Rehabilitation Center at the University Medical Center in Jackson. He took this photo of this sunset on a cotton field in the Mississippi Delta.

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## The Epidemiology of Stroke in Mississippi and the United States

Alan D. Penman, MBChB, MSc, MPH

### **S**troke incidence and mortality in Mississippi

In Mississippi in 1996, stroke (ICD-9 codes N430-N438) was responsible for 1,691 deaths (6.4% of all deaths), behind heart disease (9,499 deaths, 35.8% of all deaths) and cancer (5,732 deaths, 21.6% of all deaths).<sup>1</sup> The overall average age-adjusted stroke mortality rate over the period 1991-1995 was 34.4 per 100,000 population, 30% higher than the average for the U.S. (Table).

The exact incidence of stroke in Mississippi is unknown as the state has no stroke register or statewide hospital discharge data system. A very rough estimate is that more than 5,000 Mississippians suffer a stroke each year. 85% are of the ischemic variety and the remaining 15% are hemorrhagic. Approximately one-third of victims die, one-third become disabled, and one-third recover.

**Table 1. Stroke mortality rates by race, Mississippi and the U.S., 1991-95, and the Year 2000 objectives**

	Mississippi	U.S.	Year 2000 objectives	
			Baseline	Target
All	34.4	26.5	30.4	20.0
White	27.7	24.5	n/a	n/a
Black	52.8	45.4	52.5	27.0

Source: 2, 3.

All rates are per 100,000 and are age-adjusted to the 1940 U.S. population.

n/a = not available

## Age, sex, and race differences in stroke incidence and mortality

Stroke rates increase steeply with age after the age of 45. The risk of stroke doubles with each succeeding decade after the age of 55, and nearly three-quarters of all strokes occur in people over age 55. The corollary is that 28% of stroke sufferers are under age 65.<sup>4</sup> Overall mortality rates are about 80-90% higher among blacks. Males have slightly higher rates than females in almost every age group.

## County distribution of stroke mortality in Mississippi

Stroke mortality rates (per 100,000 population) show a wide geographic variation, ranging from 19.4 (Prentiss) to 86.5 (Holmes), a difference of 345%. Many of the counties with the highest rates are located in the Delta region. Several counties (Quitman, Coahoma, Grenada, and Holmes) have rates 50% or more above the state rate. Only nine of the state's 82 counties are *below* the U.S. average stroke mortality rate of 26.5.

## The 'Stroke Belt'

Over the period 1991-1995, Mississippi's stroke mortality rate of 34.4 was the fourth highest in the U.S. (after South Carolina, Arkansas, and North Carolina) and 60% higher than the lowest state rate (Massachusetts, 21.0).<sup>2</sup> Mississippi is one of eleven states in the southeast region of the U.S. known as the 'Stroke Belt'; this region has for at least 50 years had higher stroke death rates than other U.S. regions.<sup>5-7</sup> This could be the result of greater disease severity or factors influencing medical practice and availability of / access to care, but is most likely due to higher stroke incidence,<sup>8,9</sup> though the usual stroke risk factors can at best explain only a small

part of the variation in stroke incidence between regions.<sup>9</sup>

## Stroke risk factors

Hypertension is by far the most important factor, both in middle and old age,<sup>10,11</sup> followed by smoking<sup>12,13</sup> and elevated cholesterol<sup>14</sup>; these three factors have both the highest relative risks for stroke and the highest population attributable risks (defined as the percentage of strokes in the population that can be attributed to that risk factor).<sup>15-17</sup> In Mississippi in 1997, 23% of adults were current smokers, 34% had high blood pressure, and 29% had an elevated cholesterol (Penman AD, unpublished data from the Mississippi Behavioral Risk Factor Surveillance System).

## Time trends in stroke incidence and mortality

Stroke mortality in the U.S. has been declining in all age/sex/race groups since the turn of the century, with accelerations of the decline in the 1950s and again in the 1970s.<sup>18</sup> Between 1970 and 1985, rates in both men and women fell by more than 50% (that is, about 5% per year). This has been due partly to decreasing stroke incidence and partly to declining case fatality rates. Stroke incidence began to decline in the 1950s for women and the 1960s for men.<sup>18,19</sup> The decline in stroke incidence may now be slowing (to about 2-3% per year)<sup>20</sup> or even reversing, the result, at least in part, of more sensitive diagnostic procedures resulting in improved ascertainment of milder cases.<sup>17,18,21,22</sup>

In Mississippi, stroke mortality rates for white males and females and black females declined until the early 1990s then leveled off; rates for black females declined again in 1995 and 1996. Rates for black males have shown a more erratic trend and appear to be rising again. (Figure). The reasons for this are unknown and, as mentioned earlier, state-specific stroke incidence or hospitalization data are not available.

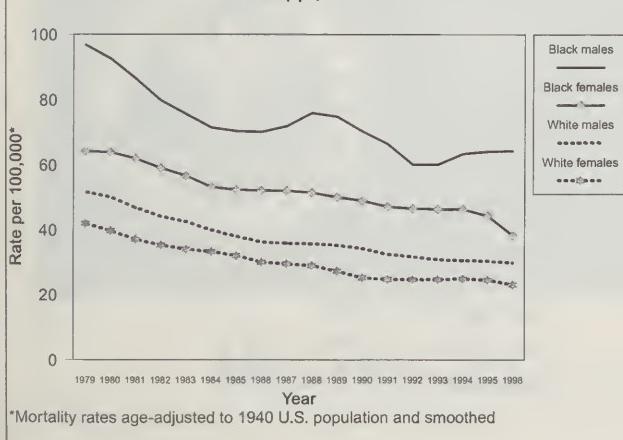
There is still no consensus that better and more widespread treatment and control of hypertension is primarily responsible for the decrease in stroke incidence and mortality; it has been suggested that, at most, a quarter of the decline can be explained by better treatment of high blood pressure.<sup>23-25</sup> Similarly, changes in the prevalence of other known risk factors can provide only a partial explanation for the declining rates.

## Projections into the 21st century

A number of variables such as the aging of the population (in particular, the rapid increase in the proportion of the very elderly ( $\geq 85$  years))), changing incidence and mortality rates, birth cohort (generational) effects,

Figure 1. Stroke mortality rates by year, race, & sex

Mississippi, 1979-1996



and changing levels of risk factors need to be considered. A further factor to consider is the improved management of coronary heart disease and the declining coronary heart disease mortality rate, which is increasing the pool of coronary heart disease survivors who are at high vascular risk and susceptible to stroke.<sup>26</sup> All in all, without major changes in the public health approach to stroke prevention, stroke incidence will likely continue to increase, though there will be a trend toward more milder strokes, diagnosed at later ages. If case fatality rates improve faster than incidence rates rise, stroke mortality rates should decline. The actual numbers of stroke sufferers and survivors will increase, however.

## Summary

Given current trends, Mississippi will not come close to meeting the National Health Promotion and Disease Prevention Objectives for the Year 2000 for reducing stroke mortality (**Table**). Without major population-based public health initiatives, stroke will remain a leading cause of morbidity, disability, and mortality and a major source of health care costs in the state for the foreseeable future.

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# Endoscopic Treatment of Inverted Papilloma

C. Ron Cannon, M.D.

## A bstract

Inverted papilloma is an unusual but important lesion occurring in the nose and paranasal sinuses. These lesions are generally considered benign although about 10% may undergo malignant degeneration and become an invasive squamous cell carcinoma. This lesion may involve the nasal septum but more commonly involves the lateral nasal wall. Although benign histologically, it is aggressive and prone to recurrence.

Treatment in the past has consisted of aggressive surgical treatment, usually consisting of a medial maxillectomy and ethmoidectomy. As the lesion is generally benign histologically, radiation therapy and chemotherapy are generally not utilized as treatment options. The purpose of this article is to present two cases of inverted papilloma treated by an endoscopic approach as well as to discuss the technique and indications for this procedure.

**CASE REPORTS:** (1) A 75 year old black male presented with complaints of right sided nasal obstruction. On physical examination, he was found to have an exophytic whitish lesion in the right nasal cavity extending from the region of the right middle meatus. (Figure 1) A coronal CT scan was obtained and showed the disease localized to the region of the right middle meatus and ethmoid sinus. He underwent endoscopic resection of the inverted papilloma in June 1995. His postoperative course was benign and on serial follow up examinations, there has

been no recurrence of the papilloma over a four year period. A recent endoscopic examination revealed no recurrence of the papilloma (Figure 2).

(2) A 68 year old white male presented with symptoms of recurrent right-sided sinusitis. On intranasal examination, he too was found to have a mass involving the right middle meatus of the nose with no evidence of any septal involvement. A coronal CT scan showed localized involvement of the middle meatus region of the nose, ethmoid sinus and medial aspect of the maxillary sinus. (Figure 3) Endoscopic resection of the mass was carried out without complication. Histology report indicated a benign inverted papilloma. Follow up to the present (3.5 years postoperative) has not shown any evidence of any recurrent papilloma.

**COMMENT:** Inverted papilloma is an uncommon lesion occurring primarily in the lateral wall of the nose. It has a characteristic histologic appearance in that the epithelium inverts into the underlying stroma.<sup>1</sup> The most common symptom of an inverted papilloma is simply that of nasal obstruction.<sup>2,3</sup>

This unilateral nasal obstruction occurred in approximately 78% of the patients in a series by Waitz.<sup>2</sup> Other symptoms are those of headache, rhinorrhea, epistaxis, periorbital swelling, or decreased sense of

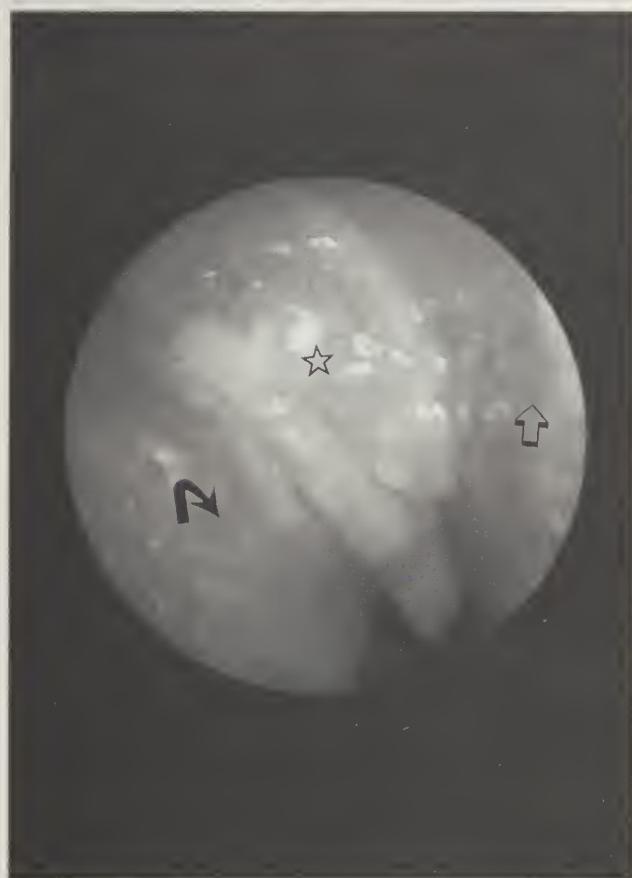


Fig 1.— Inverted papilloma (star symbol) right nasal cavity near region of middle meatus. (Curved arrow, inferior turbinate. Clear arrow, septum)



Fig 2.— Endoscopic examination 4 years post operative indicating no recurrent tumor. (Arrow, maxillary sinus. Star, middle turbinate. Double star, nasal septum.)



Fig 3.— CT scan showing inverted papilloma (star symbol) in region of lateral wall of left nose. Note the lack of bony destruction.

smell. The lesion occurs most commonly on the lateral nasal wall in the region of the middle meatus of the nose.<sup>3</sup>

Occasionally, it may occur on the nasal septum.

This lesion is important because of its propensity for being aggressive locally. It often invades adjacent bony structures. It is also important because it can invade the surrounding structures such as the orbit, nasolacrimal apparatus and the brain. It has significant destructive capacity in these regions. The propensity of inverted papilloma for local recurrence leads to multiple surgeries which have the potential for being disfiguring. Additionally, a small but significant number (10%) may degenerate into a squamous cell carcinoma. Previously, the treatment of choice for these lesions-has been that of a medial maxillectomy which involves a curvilinear incision alongside the nose externally. Vrabec recommends a wide local excision of the lesion and reports a 2% recurrence rate.<sup>3,4</sup> Others, however, have reported recurrence rates of up to 87%.

More recently, there has been an interest in endoscopic resection of inverted papilloma.<sup>5,6</sup> Kamel has reported a study of 17 patients with inverted papilloma treated endoscopically with no recurrence in any of the patients treated.<sup>7</sup> He divided the inverted papilloma into

two groups from an anatomic standpoint. For lesions without involvement of the maxillary sinus, intranasal endoscopic resection was felt to be effective. For those patients with maxillary sinus involvement, a transnasal medial maxillectomy performed under endoscopic control was recommended. McCrary, et al, reported on 7 patients treated endoscopically for inverted papilloma.<sup>8</sup> In that study, there were four primary tumors and three patients with recurrent tumors. They report no evidence of recurrence since the endoscopic treatment. Stankiewicz reported on 15 patients treated endoscopically for an inverted papilloma and only 1 was recurrence.<sup>9</sup> This patient subsequently underwent a medial maxillectomy for control of the lesion. Finally, Waitz, et al, reported on 51 patients with inverted papilloma.<sup>2</sup> Thirty-five were treated endoscopically and 16 had surgery via an extranasal approach. Recurrence rate following endoscopic surgery was 17% as compared to 19% after the extranasal operation.<sup>2</sup>

One of the advantages of this procedure is that it is performed intranasally with no external incisions. The amount of mucosa removed is minimized. This leads to normal mucociliary clearance of nasal secretions, as well as normal moisturization and warming of inspired air. Areas which can be treated endoscopically are those of the nasal cavity, septum, ethmoid and sphenoid sinuses as well as the medial wall of the maxillary sinus. An important part of this procedure is that of follow up and frequent follow up every 2-3 months is recommended.

**SUMMARY:** Endoscopic resection of inverted papilloma involving the nasal septum and lateral wall of the nose is indicated in selected cases. Careful endoscopic monitoring of the patient every 2-3 months is mandatory. Traditional surgery is reserved for more extensive lesions, recurrent lesions, or patients who have developed squamous cell carcinoma arising from an inverted papilloma. An important part of the procedure is careful informed consent. The patient should be made aware of the possibility of recurrent lesion and the need for more extensive surgery in the future as the result of any recurrence.

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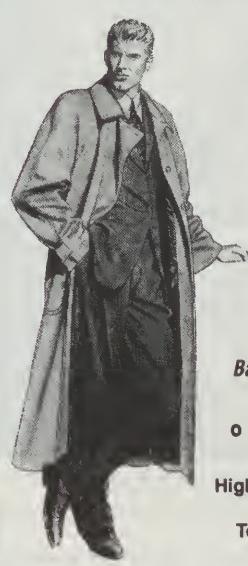
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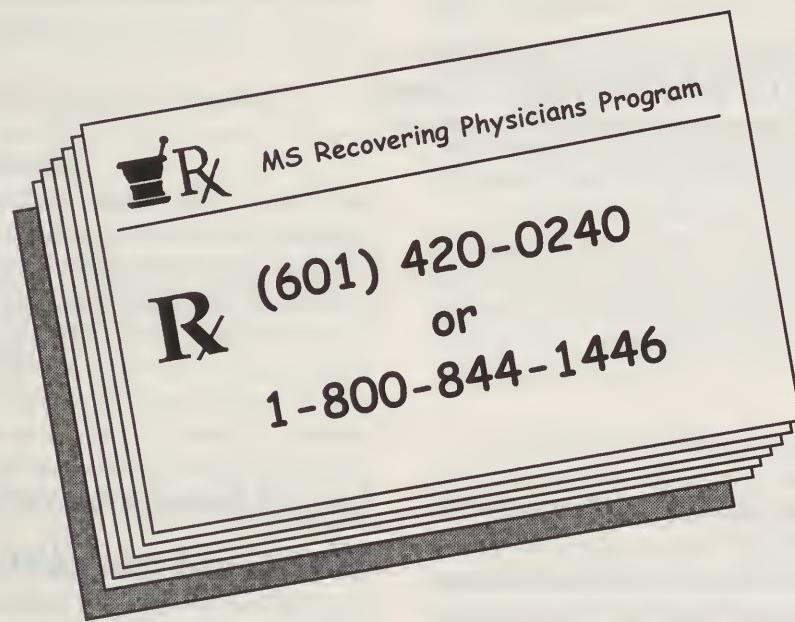
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# The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice

*[This is the third of a continuing series of excerpts published with permission from **The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice**, published by the American Medical Association, 1999 —Ed.]*

**W**hat are the legal ramifications of the Year 2000 Problem?

- Lawsuits related to the Year 2000 problem are expected to fall into one of the following categories:
  - Litigation filed by clients whose finances or investments have been damaged.
  - Litigation by shareholders of companies whose software does not safely make the Year 2000 transition.
  - Litigation associated with any deaths or injuries resulting from the Year 2000 problem.
  - Class-action litigation filed by various affected customers of computers or software packages.
  - Litigation filed by companies who have utilized out-source vendors, contractors, consultants, or commercial Year 2000 tools but where Year 2000 problems slipped through and caused damage.
  - Litigation against hardware manufacturers such as computer companies and defense contractors if the Year 2000 problem resides in hardware or embedded micro-code as well as software.

## Legal Fundamentals (Contract and Tort Law)

### Introduction

Your legal rights against, and potential liability to, others will be dictated largely by theories of contract and "tort" law. (Contract law governs the rights of the parties when one of them has failed to do what the contract promises. Tort law governs the rights of a person or entity against which a wrongful act has been committed, either deliberately or negligently.) As a result, understanding basic legal principles of contract and tort law is important both in pursuing and in defending against litigation, as well as in designing and implementing your Year 2000 compliance plan. The goals of this chapter are to provide you with a basic knowledge of these concepts, and to help you evaluate potential contract and tort claims that your practice may have against others as a result of the Year 2000 problem, as well as potential claims against your practice due to the Year 2000 problem.

## **Gain an Understanding of the Fundamental Legal Principles Implicated by the Year 2000 Problem**

### **Contract Law**

Understanding contract claims is crucial to evaluating your rights and obligations for Year 2000 problems. Such claims may involve contractual "warranties." Claims may also be expressly limited, under the contract's language. Your contracts with technology vendors and other entities will contain warranties, limitations on warranties, and/or limitations on remedies and damages. These contractual provisions may or may not be enforceable, depending on the particular facts and circumstances and also on whether the contractual relationship is governed by the Uniform Commercial Code ("UCC").

### **Warranties - Express vs. Implied**

#### ***Uniform Commercial Code***

The UCC is a relatively uniform set of laws adopted by most states, which applies to contracts for the sale of goods (ie, products, as opposed to services). Generally speaking, the UCC does not replace the terms of a contract for the sale of goods, but does govern the party's rights and liabilities when the contract is silent a particular issue. In some circumstances; however, the UCC may alter or affect the enforceability of certain contractual provisions, such as disclaimers of warranties and limitations on remedies and recoverability of damages.

A warranty is essentially a promise, that a product or service will be performed according to certain specifications or at a particular level. *Express warranties* can arise from the language of a contract, and in some cases also from statements made by the other party regarding the quality, characteristics and/or performance of the product (e.g., written or oral statements made in person, in advertising or marketing materials or in product documentation. But, see the discussion of integration clauses below). Additionally, warranty language found in the contract itself will often discuss the types of remedies that will and will not be available for breach of the warranty. Finally, it is important to remember that you may have a claim for breach of an express warranty against a manufacturer (e.g., for statements made in promotional materials) even if you purchased the product from an intermediary.

In addition to any express warranties that may exist in a contract, the UCC creates two *implied warranties* that arise automatically unless expressly disclaimed - the implied warranty of "merchantability" and the implied

warranty of fitness for a particular purpose:

- **Merchantability** - This is a warranty that the product is suited for the ordinary purpose for which such products are sold and used. This warranty passes from the manufacturer down the chain of distribution to, and can be asserted by, the ultimate user, regardless of whether a contract exists between the manufacturer and buyer. It is also deemed to have been given, unless expressly disclaimed, by the entity that actually sold to the buyer.
- **Fitness for a Particular Purpose** - This warranty applies only when the seller knows **the product is being purchased to meet** a specific need, and that the purchaser is relying on the superior skill and knowledge of the seller to provide a product that satisfies that need.

#### **Anticipatory Repudiation and the Right to Adequate Assurances of Future Performance**

Another important tool in assessing your contractual rights is the concept of "anticipatory repudiation," and the related right of a party to demand "adequate assurances of future performance." In the Year 2000 context, these principles are particularly applicable to vendor inquiry letters.

*Anticipatory Repudiation* takes place when one party to a contract clearly indicates (through its conduct or statements) to the other party that it does not intend to perform under the contract. When this happens the non-breaching party can refuse to continue its own performance under the contract and proceed instead to make other arrangements, if necessary, to mitigate its damages.

### **Practical Tip**

*It is not always clear when anticipatory repudiation has taken place. For example, if a contract party warns you that it "may" have trouble meeting its responsibilities, that probably does not constitute anticipatory repudiation.*

Even if there has not been an act of anticipatory repudiation, if under the existing factual circumstances you have "reasonable grounds for insecurity" with respect to your contracting party's continued performance, you have the right to formally demand *adequate assurances of future performance*. If such assurances are not provided within a reasonable period of time you may then suspend your own further performance under the agreement and treat the contract as having been breached by the

other party. (As a result, for example, you would not have to wait for an actual Year 2000-related failure before taking action to remedy the Year 2000 problem using an alternative source, and, if desired, filing a lawsuit against the defaulting party.)

## Practical Tip

*As with anticipatory repudiation, whether or not "reasonable grounds for insecurity" exist and whether or not the other party to the contract has provided "adequate assurances" in response to your request are fact-intensive inquiries, and will depend on the particular circumstances.*

### Defenses to Contract Claims

**Disclaimers or Exclusions of Express Warranties** Contract law generally permits sellers to disclaim or limit warranties, including the implied warranties, as long as the disclaimer is "clear and conspicuous." Most technology vendors do in fact limit the scope and duration of warranties. (If, however, the contract contains both what purports to be a general disclaimer of all warranties, but also some specific, express warranties, a court may find the general warranty disclaimer to be inoperative.)

## Practical Tip

*Computer system specifications, if incorporated into the contract, might well constitute express warranties that could be unaffected by the presence of a general disclaimer of warranties.*

### Disclaimers or Exclusions of Implied Warranties

The UCC allows sellers to disclaim the implied warranties of merchantability and of fitness for a particular purpose. To disclaim the implied warranty of merchantability the disclaimer (a) should be in writing, (b) if in writing, must be conspicuous, and (c) must mention the word "merchantability." The disclaimer of the implied warranty of fitness for a particular purpose must be in writing and must be conspicuous (e.g., in larger or other contrasting type or in a different color from the rest of the contract). In addition to specific disclaimers the UCC permits blanket disclaimers of implied warranties through, for example, the use of terms such as "as is," "with all faults," or other language that in common understanding calls the buyer's attention to the exclusion of warranties and make plain that there is no implied warranty. Most technology contracts disclaim (or attempt to disclaim both of the implied warranties. (Although these disclaimers are typically valid, they may be ignored by a court if it

appears under the circumstances that the waiver was "unconscionable.")

### Example - Typical Vendor Implied Warranty Disclaimer

Except as specifically provided in this agreement, there are no other warranties, express or implied, including, but not limited to, any implied warranties of merchantability or fitness for a particular purpose

**Limitations on Remedies or Damages** - Many contracts, especially technology contracts, contain limitations on both the types of remedies and the amount of damages that are available in the event of a breach of the contract by the vendor. As a result, even if an express or implied warranty applies and has been breached, you may be limited as to what remedies are available. Typically, these clauses limit the purchaser to a specific remedy such as repair or replacement of the defective product, or damages only up to a specified dollar limit (often the amount of the purchase price). Such clauses also typically attempt to exclude all liability of the seller for "incidental," "indirect," and "consequential" damages (e.g., damages awarded against you in a legal action by a third party arising out of failure of the vendor's product).

### Example - Typical Vendor Limitation on Remedies and Damages Clause

Seller shall not be liable to any party for any exemplary; punitive, special, incidental, indirect, unforeseen or consequential damages, including lost profits, lost revenues or loss of reputation, arising directly or indirectly from any cause related to this Agreement.

As with disclaimers of warranties, limitation of remedy clauses are scrutinized carefully by the courts but are usually upheld. However, courts may not enforce a limitation if it is ambiguous, is deemed unconscionable (i.e., if it was imposed by one party upon the other and there was significant disparity in bargaining position), "fails of its essential purpose" (e.g., if a seller limits the remedy to repair or replacement of the product, but is unwilling or unable to do so), or was induced through fraud.

## Practical Tip

*Sellers may argue that any contractual warranty was expressly limited to a specific time period, e.g., one*

*year after delivery of the product, and that such time period has passed. This is especially a problem with regard to Year 2000 defects, since the defect was probably not apparent at the time of delivery.*

*In response, purchasers should argue (if appropriate) that even though they, did not notify the seller of a warranty defect during the initial warranty period, the Year 2000 bug was inherent in the product, the product was in fact therefore defective, and the purchaser should not be prejudiced by the fact that the defect did not appear until after the warranty period had ended.*

**Failure to Mitigate Damages.** Even when one party to a contract has breached the contract, the injured party cannot recover damages flowing from consequences that it could reasonably have avoided. Although extraordinary efforts are not required to avoid or minimize damages, the injured party must exercise reasonable diligence in doing so. This defense also has a necessary corollary - the party that reasonably attempts to mitigate its damages is entitled to recover from the breaching party the reasonable expenses incurred in its mitigation efforts.

## Practical Tip

*Once a Year 2000 problem is identified, prompt remedial action should be taken to minimize the consequences, expenses and damages caused or that potentially could be caused by the problem, such as notifying the potentially responsible party, and reasonable steps to effectively remedy or work around the problem if the responsible party cannot or will not do so.*

**Commercial Impracticality.** A contract may be "commercially impractical," and therefore unenforceable against the breaching party, when it can be performed only at excessive or unreasonable cost. This can apply to remedies as well. As a result, sellers of technology products may argue that the repair remedy in the contract should be deemed unenforceable because making the product Year 2000 compliant would be too expensive or burdensome. The success of this argument will depend upon the facts of the particular case, and whether other remedies are available to the purchaser.

**Statute of Limitations.** In general, lawsuits must be filed within a period of time defined by the applicable "statute of limitations." The statute of limitations for contract actions varies by state and by type of claim, and may also generally be limited by the language of the contract. The UCC usually provides that a breach of

contract action must be brought within four years after the cause of action "accrued." For breach of warranty claims, the cause of action accrues when delivery of the product is made, regardless of whether the purchaser knows the product is defective. As a result, under the UCC a purchaser who took delivery of a product before 1996 may be barred from bringing a breach of warranty action if it waits to do so until the software fails in 2000. (An exception to this four-year period under the UCC arises when a warranty explicitly extends to future performance of the goods and discovery of the breach must await the time of such performance, for example if a software license contains representations concerning the useful life of a product.)

## Practical Tip

*Although a strategy of cooperation and open discussion and negotiation with parties potentially legally responsible to your practice is often the appropriate course, when in doubt it is imperative to protect your rights by filing suit before the earliest possible time that an applicable statute of limitations could run, or alternatively by obtaining a "tolling agreement" whereby the defendant agrees in writing to extend the applicable statute of limitations.*

*Purchasers of non-compliant products may attempt to extend the otherwise applicable statute of limitations period by arguing that subsequent promises by vendors to fix the Year 2000 problems constituted new or supplemental agreements that extend the start date for the applicable statute of limitations.*

**"Force Majeure" Clauses.** Contracts often contain clauses that provide that a party will not be deemed in default if the breach is a result of an "act of God" or other cause outside the control of the party. Although it is unlikely that a typical Year 2000 problem would be considered such a cause, if broadly worded such a clause could be deemed applicable.

### Example - Typical Vendor Force Majeure Clause

**Force Majeure.** No party shall at any time be deemed to have breached any obligation under this Agreement or be in default hereunder or be liable for damages by reason of any circumstance or delay resulting from an act of God, riot, insurrection, war, or resulting from any cause beyond such party's control.

### Integration Clauses.

An integration clause, if found in a contract, may

limit warranties to those contained in the written agreement (and thus may prevent a buyer from relying on other oral or written representations or advertising). (There are certain exceptions that allow a contract to be interpreted or explained, but not varied from the written contract, using this type of "extrinsic" evidence even if an integration clause exists, but these should not be relied on.) If an integration clause exists, all representations of the vendor that the purchaser is relying on should be reduced to writing and included in the agreement itself, for example as exhibits to the agreement.

### **Example - Integration Clause**

**Entire Agreement.** This Agreement constitutes the entire agreement between the parties with respect to the matters herein referenced, and supersedes all other prior agreements, understandings, promises or representations, written or oral, between that parties with respect to such matters.

### **Tort Law**

Your practice's rights and obligations are also affected by principles of tort law. Tort theories include fraud, misrepresentation, negligence, failure to warn, failure to recall or retrofit, and "strict liability."

**Interaction with Contract law (The Economic Loss Doctrine).** Tort theories will be particularly relevant whenever the contract principles discussed above do not apply to a particular situation. Even if contract principles do apply, moreover, there may be a tactical advantage to a plaintiff in litigation or negotiations if tort principles apply in addition to contract law. For example, contractual language purporting to limit remedies and damages should not be effective with regard to tort claims. Also, punitive damages (ie, "extra" damages the defendant must pay that are intended to punish the wrongdoer in particularly egregious situations) may be available in a tort case but are generally unavailable in contract actions.

However, there is an important limitation on the availability of tort recovery to a plaintiff. Under the "*economic loss rule*" a party is often barred from recovering "economic" damages (ie, business losses as opposed to losses from personal injury or damage to property) through a tort claim if the litigants are parties to a contract concerning the transaction or occurrence that caused such damages. Thus, in the absence of personal injury or property damage it is more likely that your rights and obligations will be determined under any existing contract than under tort principles. (However, there are exceptions to the economic loss rule that can be explored

with your attorneys.)

**Fraud and Misrepresentation.** If a party has been improperly induced to enter into a contract (e.g., to purchase a particular product), the purchaser may be entitled to recover under a tort claim of fraud or misrepresentation without being limited by either the economic loss rule or by purported limitations on remedies and damages contained in the contract. To establish a claim of fraud or misrepresentation, the purchaser must demonstrate that:

- (1) the seller made false representations to the purchaser;
- (2) the seller made such representations knowing they were false (or with reckless disregard for their truth or falsity);
- (3) the representations were "material" (i.e., the purchaser would not have entered into the contract or transaction but for the false statements);
- (4) the purchaser relied (took some action or failed to take some action) on the false representations; and
- (5) the purchaser suffered damages as a result of its reliance on the false statements.

In addition to liability for affirmatively making false statements, liability may also be imposed as fraud or misrepresentation for failing to disclose material facts.

### **Practical Tip**

*A statement that a product or system will be functional beyond the Year 2000 or that it will satisfy your practice's needs "into the future" may be actionable misrepresentation if the product or system is not Year 2000 compliant. Statements that a system is "error free," "bug free," "free of defects," "debugged," etc., may likewise give rise to a claim of misrepresentation.*

**Year 2000 Legislation.** The federal "Year 2000 Information and Readiness Disclosure Act" was signed into law on October 19, 1998. The intent of the Act is to provide liability and other legal protections to businesses that would "promote disclosures and exchanges" of information about year 2000 compliance status. While the Act does provide some important protections, it also contains many exceptions, exclusions, and ambiguities which undermine those protections.

**Negligence.** A claim based on negligence is essentially a claim that the defendant failed to act in accordance

with the applicable standard of care, thereby causing injury or damage to the plaintiff. The exact standard in practice will differ according to the facts of the particular case. Negligence claims are the centerpiece of medical malpractice lawsuits, of course, and will surely be implicated if a patient is harmed as a result of a Year 2000-related failure. The most effective way to protect your patients and insulate your practice from a claim of negligence with respect to the Year 2000 problem is to take the steps set forth in these Guidelines to identify and remedy all Year 2000 problems that are at all likely to arise in your practice. In addition, as devices and systems fail, you or your practice may be called upon to perform procedures or tasks that have been previously unnecessary due to the existing technology. To the extent your contingency planning includes replacing a failed device or system with a manual procedure, you should ensure that all appropriate personnel are properly trained and capable of performing the procedure.

## Practical Tip

*The general rule is that a physician cannot obtain a release from legal liability for his or her negligent behavior simply by inserting release language in a patient consent form. Therefore, if an injured patient claims that the physician failed to take reasonable steps to ensure patient safety (e.g., to follow the recommendations found in these Guidelines) the physician probably cannot protect himself or herself by obtaining the patient's consent. This said, if you have not obtained reliable information, through testing or otherwise, that an item of medical equipment is Year 2000-compliant and will function properly, the physician should disclose to patients through the informed consent process that the Year 2000 problem creates risks that the device(s) and system(s) may fail, and, when appropriate, that patient harm is a potential consequence. Such a disclosure would at the very least act to enable the patient to make an informed decision to proceed and protect the physician from a claim that the physician (negligently or otherwise) failed to disclose, or failed to warn of, the risks involved. Failure to do so may place the physician in the shoes of the manufacturer with regard to a products' safety.*

**Strict Product Liability.** So-called "strict liability" is usually imposed by the law only upon manufacturers and sellers of defective products. (Generally, cases have held that strict liability is not imposed as a result of injury arising out of the provision of services, nor for any

products that may have been used merely incidentally during the course of providing medical services.) Strict liability focuses on the product sold by the defendant, rather than the defendant's conduct. The plaintiff in a strict liability case must generally prove that the product (1) was defective; (2) was unreasonably dangerous; (3) reached the plaintiff from the defendant without substantial change; and (4) caused damage to the plaintiff. In addition, liability will be found only if the product was being used in a manner actually intended or reasonably foreseeable by the manufacturer or seller. Finally, recovery under a strict liability theory is limited to injury to persons and damage to property other than the product itself.

## Practical Tip

*Strict liability is imposed for products and not services. As a result, courts may be reluctant to apply strict liability principles to information technology systems or software, which may appear less like machines and more like an "intellectual assistance" product, such as a book. For example, software that determines the dosages of drugs to be administered to a patient is more likely to be treated as a service than as a product subject to the strict liability doctrine.*

A supplier or seller of a product can be found liable for "failure to warn" under a strict liability theory. A manufacturer, seller or supplier of goods has a duty to use reasonable care to give those who use the product the information necessary to make use of the product safe.

## Defenses to Tort Claims

Even if the elements of a tort claim are established, recovery by the plaintiff may be reduced or eliminated by legal defenses available to the defendant. These are briefly discussed below.

**Contributory Fault/Comparative Negligence.** In a negligence claim, a plaintiff's failure to read or follow warnings, or other fault that contributed to plaintiff's incurring damages, will not generally preclude all recovery. However, it will reduce the amount the plaintiff can recover, in proportion to the extent that its own negligence caused its injury or damages, and in some states recovery is totally precluded if the plaintiff's contributory negligence exceeds the degree of the defendant's negligence.

**Assumption of Risk.** A plaintiff's voluntary assumption of the risk involved with the use of a product can be a

complete defense to a tort cause of action. Thus, if a user of a product is aware of the danger, but nevertheless proceeds to use the product, he or she may not be able to recover.

**Statutes of Repose.** Many states have “statutes of repose,” that bar any lawsuit concerning alleged defects in a product that is filed more than a certain number of years after the product was manufactured and/or sold. Depending on the particular language of the statute, it may or may not also preclude a claim based on a post-sale duty to warn.

**Statutes of Limitations.** As discussed above in the context of contract claims, a statute of limitation bars lawsuits unless they are brought within a certain number of years after the claim arises. Usually the statute of limitations is shorter under tort law than under contract law. However, contract statutes of limitations may begin to run immediately at the time of purchase, whereas for tort claims the limitations period usually does not begin to run until the acts giving rise to the claim become known by (or should have been known by) the plaintiff or until the acts actually produce injury.

## Practical Tip

*As described above with regard to contract claims, purchasers of non-compliant products may attempt to extend the otherwise applicable statute of limitations period by arguing that subsequent promises by consultants or vendors to fix the Year 2000 problems constituted new or supplemental agreements that extend the start date for the applicable statute of limitations.*

## Identify Relevant Relationships

### Create Lists of Potential Plaintiffs, Defendants and Other Parties/Witnesses.

The first step in determining your legal rights and obligations in connection with the Year 2000 problem is to generate lists of the various relationships involving your practice. The following are potential relationships and factual contexts in which a Year 2000 problem and corresponding legal right or duty might arise:

- **Technology Suppliers/Vendors.** Your accounting system fails because it is not Year 2000 compliant and as a result you are unable to process bills to patients or payors, or pay your practice's own bills. You may have claims against the technology vendor that supplied the

software, for breach of contract, breach of warranty, fraud, negligence, and/or strict product liability.

- **Non-Technology Suppliers/Vendors.** One of your suppliers is unable to make deliveries because the supplier's automated delivery system is not Year 2000 complaint. The lack of supplies materially affects your practice's ability to treat patients. You may have claims against the supplier for breach of contract, breach of warranty, fraud and/or negligence.

- **Patients.** Under the scenario discussed above, your inability to obtain supplies causes harm to a patient. That patient may have a negligence claim against your practice.

- **Business Partners.** Your practice transmits corrupted data to the computer of an entity with which you do business. That business partner may have claims against your practice for, among other things, breach of contract and/or negligence.

- **Government.** The governmental computer systems used in connection with state or federal health care programs or organizations fail, and this materially damages your practice.

In contrast to the above, although you have been damaged and have valid claims against the government your claims may be limited by “sovereign immunity” principles.

## Evaluate Contract and Tort Claims

### Ascertain the Problem (or Potential Problem) and Determine Whether it is Year 2000-Related.

**Determine Applicable Contract Language.** If a contract exists, it must be reviewed to determine if there has been a breach. Very few contracts will expressly address Year 2000 compliance. In the absence of such language alternate provisions or warranties that relate more generically to defects, deficiencies, or “bugs” must be reviewed to determine whether they may be interpreted as encompassing Year 2000 compliance deficiencies.

- **Express Warranties.** Review all applicable documentation for express warranties. In assessing your warranty rights, you will need to consider:

- the nature, scope and extent of any representations made by the vendor as to what the performance of

the system or product would be;

- the provisions of the agreement pertaining to express and implied warranties, and limitations on such warranties;
- and the duration of applicable warranties.

**• Implied Warranties.** In addition to evaluating express warranty claims you should also evaluate potential claims for breach of an implied warranty. For example, you may be successful in arguing that technology products that are not Year 2000 compliant are not "merchantable." In addition, the warranty of fitness for a particular purpose might have been breached if you relied on the vendor's expertise to specify a product with an express or implied useful life that extended into the next century. In such a case a request that the product be Year 2000 compliant, while not made expressly, may be inferred. Once again, the contract should be reviewed for disclaimers or exclusions of the implied warranties.

- Consider Whether There Has Been an Anticipatory Repudiation of the Contract or Whether You Should Demand Adequate Assurances of Future Performance

- Review the Defenses to Contract Claims.

- Determine if the Problem Gives Rise to a Tort Claim.

- If a Tort Claim Exists, Consider the Defenses to Such a Claim.

- If You or Your Practice Are the Potential Plaintiff in the Claim, Consider Whether You Should Contact Your Attorney or Notify the Vendor and Negotiate Solutions.

*W*

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372N06



- **If You or Your Practice Are the Potential Defendant in the Claim, If Possible Attempt To Fix the Problem that May Give Rise to the Claim.** If it is too late to prevent the event that may give rise to the claim, you should contact your attorney.

For practical answers to Y2K questions, and a variety of useful resources and Web links, please visit the AMA Y2K Web site at <http://www.ama-assn.org/not-mo/y2k/index.htm>.

### AMA Members May Download Free Copy of Important Y2K Publication

*The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice* is hot off the press and ready to assist physicians in their preparation for the year 2000. The manual provides an overview of the issues and

raises physician awareness of the potentially devastating operational and financial implications of failing to understand and address these issues within their practices. Some of the topics include: liability of corporate officers and directors, legal fundamentals, insurance coverage, medical equipment and payment/billing issues. The 73-page publication contains more than 26 "practical tips" for physicians to apply during their own compliance process.

AMA members may download the entire document from the AMA Web site at <http://www.ama-assn.org/not-moly2k/protguid.htm>. The publication can be ordered by calling the Customer Service Center at (800) 622-8335. The cost of the publication is \$25 for AMA members, and \$100 for nonmembers.

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# Confidentiality and Privilege of Physician Peer Review

Philip T. Merideth, M.D., J.D.

Physician peer review is an important function of a health care organization's medical staff which has enjoyed broad protection from disclosure in legal proceedings under a Mississippi privilege statute. However, a recent decision by the Mississippi Supreme Court has limited the scope of the privilege previously afforded to medical staff peer review proceedings.

The terms "confidentiality" and "privilege" are used frequently to describe similar concepts. Confidentiality ("CO") is the *clinician's obligation* to keep a patient's disclosures confidential and is a legal and ethical duty of physicians. The physician-patient privilege ("PR") refers to the *patient's right* to prevent specifically protected information from being disclosed in a legal proceeding. Information may be privileged in other contexts, such as the attorney-client privilege or the medical staff peer review privilege. Information becomes privileged only when designated as protected information by a statute or a court decision.

The proceedings and records of medical staff peer review committees have long been thought to enjoy a broad privilege from disclosure in civil litigation in Mississippi. In order to promote quality patient care through medical staff peer review proceedings, the legislature enacted privilege statutes contained in Mississippi Code Annotated Section 41-63-9 and Section 41-63-23. The legislature intended for these privilege statutes to promote the establishment of peer review commit-

tees to monitor medical staff members' activities. The legislature thought that these privilege statutes were necessary to allow peer review committees to operate effectively and to encourage self-policing by physicians so that patients can benefit from the best medical care possible. Briefly paraphrased, the privilege statutes state that the proceedings and records of a medical or dental peer review committee and accreditation and quality assurance materials are confidential and are not subject to disclosure or use in a civil lawsuit.

Until recently, the Mississippi Supreme Court had never interpreted the scope of the peer review privilege statutes. However, in deciding the case of *Claypool v. Mladineo*, the Mississippi Supreme Court took a narrow interpretation of the peer review privilege.<sup>1</sup> Therefore, Mississippi physicians and employees of health care organizations should be aware that peer review information which previously was thought to be privileged may now be subject to disclosure under the ruling in the *Claypool* case.

To state briefly the facts of the case, the patient filed a medical malpractice suit against her treating physician and the hospital. The patient's attorney requested documents concerning the physician's hospital privileges and other documents that the physician and hospital claimed were protected from disclosure by the peer review privilege statute. The trial court ruled that the documents were privileged and not subject to disclosure. The patient appealed the trial court's ruling to the Mississippi Su-

preme Court.

In deciding the Claypool case, the Mississippi Supreme Court noted that the state's peer review privilege statute had not been addressed previously by the Court. The Supreme Court reviewed the privilege statutes and court decisions from other states to reach its decision. The Supreme Court noted that, although nearly every state has some form of medical staff peer review privilege, no two privilege statutes, or the courts' interpretations of them, are alike. The Supreme Court ultimately decided that the trial court erred in interpreting the medical staff peer review privilege statute in a broad manner. The Supreme Court quoted with approval the following language from a case in another state which involved similar issues: "The privilege must not be permitted to become a shield behind which a physician's incompetence, impairment, or institutional malfeasance resulting in medical malpractice can be hidden from parties who have suffered because of such incompetence, impairment, or malfeasance." The Supreme Court stated that the peer review privilege should protect from disclosure only matters that would threaten the candor of physicians involved in a peer review proceeding.

In making this narrow interpretation of the peer review privilege statute, the Mississippi Supreme Court ruled that only the information which was considered and the discussions which occurred during a peer review proceeding are protected from disclosure in a civil lawsuit. The Supreme Court further ruled that information which could be found from another source separate from the peer review proceedings would not be privileged and could be used as evidence in a civil lawsuit. The Supreme Court concluded as follows:

The statutes do not allow a plaintiff to inquire as to the peer review proceedings themselves. A plaintiff is not entitled to a transcript of the medical peer review committee proceeding to determine what was discussed or considered by the committee. But, a plaintiff is entitled to information and documents presented to the committee in order to know what and where to find the information otherwise discoverable from original sources. Additionally, defendants who assert the privilege should be required to provide the names and addresses of all present during the medical peer review committee proceedings...*(emphasis in original)*

In light of the Mississippi Supreme Court's ruling in the Claypool case, physicians and employees of health care organizations may wish to take another look at their medical staff peer review process.<sup>2</sup>

As a starting point, physicians and employees of

health care organizations should note that the Mississippi Supreme Court ruled in the Claypool case that the peer review privilege statute applies only to committees formed for the sole purpose of peer review to promote quality assurance. Therefore, participants in the medical staff peer review process may wish to review their organization's bylaws to ensure that the description of their committee includes a statement that the committee was formed for "peer review to promote quality assurance".

Next, it should be noted that even though the records and transcripts of medical staff peer review committee proceedings are privileged, the actual results of the proceedings, such as recommended disciplinary measures, are not privileged. Therefore, persons in charge of the documentation of medical staff peer review committees may wish to consider keeping the records and transcripts of the proceedings separate from the results of the proceedings.

Also, the minutes of medical staff peer review committee proceedings should contain a list of the names and addresses of all persons present during the proceedings. The minutes should include a list of the documents received by the committee and the original source of the documents, but not the contents of the documents. The minutes also should reflect the results of the proceedings, for example, the final recommendations of the committee.

However, the information which was actually considered or generated by the committee and the content of the discussions that occurred during the committee proceedings should not be in the minutes and should be kept separate and clearly marked with the phrases "Privileged and Confidential under Mississippi Code Annotated Section 41-63-9 and Section 41-63-23" and "Produced During [or for] Medical Staff Peer Review Committee Meeting for Peer Review to Promote Quality Assurance".

Documents produced solely for the purpose of peer review or quality assurance (e.g., incident reports or internal investigations) should also be marked clearly with the same phrases. Only the original version of such documents should be maintained, because copies of documents presented to the committee may be discoverable from their original source. Undertaking such efforts to assert the peer review privilege may be cited as evidence that the information was generated with the expectation that it would be protected from disclosure.

In conclusion, the Mississippi Supreme Court's narrow interpretation of the peer review privilege statute in the Claypool case appears to allow exceptions to dilute the rule. This may seem like bitter medicine to Mississippi physicians and health care organizations. However,

the actual impact of the Claypool case on medical staff peer review information will not be known until there are future rulings by trial court judges. By being aware of changes in the law and by taking proactive measures such as those described above, those who strive to improve patient care through the medical staff peer review process can maintain what is left of the privilege.

*Attorneys who represent physicians and health care organizations should be aware of the Mississippi Supreme Court's interpretation of the peer review privilege statute in the Claypool case, and they should be consulted for legal advice in specific cases. The opinions and recommendations contained in this article are not legal advice and should not be relied on without consulting an attorney who has experience in health law.*

## REFERENCES

1. Claypool v. Mladineo, 724 So.2d 373 (Miss. 1998).
2. Ingram S. Medical Staff Discipline: An Issue of Both Privacy and Immunity. *Mississippi Medical News*. March, 1999; VIII: II, 11, 26.

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## W. Briggs Hopson, Jr., M.D. The President's Page

### Don't Condemn the Pudding Until You Have Tried It

**S**o often I hear, "I don't belong to the Mississippi State Medical Association because I don't want to belong to the American Medical Association. They don't do anything for me. If we were not a unified state, I would belong to the Mississippi State Medical Association." I wonder if the people who say this have ever been to an AMA meeting. I wonder if they look at or read the *American Medical News*. I wonder if they read the editorials and articles in *JAMA*. I wonder if they have ever viewed the House of Delegates or a Reference Committee and heard fellow physicians from all over the country discussing issues that not only affect their constituency but all of us who practice medicine in this country.

I only wish those saying this could have been in Chicago with me a few weeks ago to have heard the lively debate on a number of issues that took place in the AMA House of Delegates--issues that affect not only us here in Mississippi but physicians around the country, issues that will affect us not next year but far into the 21st century. I wish they could have heard the debate on collective bargaining, a debate that lasted over two hours and was finally decided on a very close vote. I would like for them to have heard the debate on E & M codes, and on fraud and abuse. I wish they could have heard the debate on sales of health-related products from physicians' offices. All of these issues are paramount not only to us in the state of Mississippi but to physicians around the country. I wonder if these physicians who say "the AMA does nothing for me where my specialty organization does" realize that their specialty organization is represented in the House of Delegates. They sit on the floor of delegates and discuss and vote on issues that concern not only their association but concern all of medicine. I wonder if these people have ever been in our congressional offices to discuss a medical issue only to have that congressman ask, "How does the AMA feel about this issue? What is their stance?" Yes, we all have issues but the one organization that brings all of these issues together is our AMA. I hope those of you reading this article will share it with a colleague who does not belong to the Mississippi State Medical Association and the AMA. I hope you will stress to them that only through organization and being unified can we continue to lobby for and achieve the goals we aspire to as we move into the next century.

Remember what Winston Churchill said, "A pessimist sees the difficulty in every opportunity; the optimist sees the opportunity in every difficulty."

A handwritten signature in blue ink that reads "Briggs".

## I'VE BEEN TO THE AMA, I TELL YOU

I've got to write about this one fellas; you'll have to bear with me. Last week I arrived home from Chicago and my first AMA meeting. The meeting lasts almost a full week, leaving one exhausted, enlightened, overfed, exhilarated and without any clean clothing left to put on. It is pure energy, where one meets some of the most dynamic, intelligent and interesting people he ever will meet.

As one who thinks of time away from the office in terms of backpacking in the Appalachians or mapping the Chancellorsville battlefield to find the exact spot where we crushed the Yankee right, I wasn't at all sure I would enjoy the meeting. But something in the intermingling of emotions and the synthesis of competing views into a single vision of what medicine is to be made one proud and eager to participate. And to go again.

At no point was the debate as intense and eloquent as it was over the issue of the AMA organizing union and collective bargaining activity. It rocked for five hours in the reference committee, and when the issue went to the House of Delegates several days later no one was tired. It seethed on all day, back and forth at two minutes per speaker, without repetition or dullness.

The more conservative southern and western delegations seemed to me generally opposed to union activity sanctioned by the AMA. Those from populous urban and industrial states gave emotional arguments for the idea as the only way to save the profession.

As I sat listening, opposed myself to union organization, I began to understand that those doctors for the idea were speaking of a world I hadn't seen. Regardless of how bad we think managed care has become in Mississippi, things are far worse elsewhere. A California physician told me the numbers of doctors in his area are steadily dwindling. Others spoke of colleagues having to borrow money to pay taxes after being turned out of health plans for protesting altered medical decisions. Simply put, they needed us.

They needed the unified voice we afford them by all being members of the AMA. Collective bargaining would have little impact in Mississippi and more rural states, but it is extremely important to those in other areas. The vote margin on a critical amendment offered by Florida to remove the collective bargaining language from the resolution was razor thin. The union forces prevailed. Then someone, God bless him, rose to offer another amendment—that the unions organized by the AMA would never strike. It passed by a huge majority. The relief went through the hall like the cool gust off a summer shower. We were one again.

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

The news headlined the papers the next day, but along with the nasty word "union" was an explanation why after 150 years the AMA felt compelled to express themselves in this manner, the abuses it was attempting to fight, and the fact that there would be no strikes or bargaining over fees.

Could we, the losing side, defeat collective bargaining after all? Sure, just quit the AMA. No unity, no single voice for collective bargaining or patients rights. But one day an issue will come along very important to us, and we will need them, and they will remember how we didn't quit. Besides, we've been here before and made our mistake. Don't you remember? Our grandfathers met one year in Jackson when they didn't like the social ideas coming out of Washington, and they seceded from the Union. The next thing anyone knew Generals Grant and Sherman were here with ten divisions, and Vicksburg, Jackson-and Meridian lay in shards and ashes.

Unity is the answer. Then we can accomplish something. And I'll go back to the AMA.

—*Leslie E. England  
Editor*

## **MSMA Joins with the Mississippi Public Health Association to Jointly Raise Funds to Commission a Portrait of Dr. Felix Underwood for the Mississippi Hall of Fame**

During the 131st Annual Session the MSMA House of Delegates adopted a resolution paying tribute to Dr. Felix J. Underwood. The resolution (No. 8) was introduced by Central Medical Society and Delta Medical Society.

Dr. Felix J. Underwood is perhaps the most widely-known and recognized physician in the history of our state. He was a "country doctor" in Monroe County, Mississippi who became one of our nation's best-known public health officers while serving as Executive Officer of the State Board of Health for thirty-three years.

Upon his death in 1959, Dr. Underwood was recognized in newspapers across the state and throughout the country as the "father of Mississippi's public health program" and as the "man who saved a million lives."

He was also a leader in organized medicine, having served as a member and Chairman of the Board of Trustees, and President of the Mississippi State Medical Association and as member of the Board and President of Southern Medical Association.

A leader in several voluntary health agencies, including the March of Dimes, American Cancer Society and the American Heart Association, Dr. Underwood also

held a number of important national positions, having represented the United States at international public health meetings and served as a public health advisor to President Franklin Roosevelt.

In 1996 Dr. Underwood became the first and only physician elected to the Mississippi Hall of Fame. He is one of the few members of the Hall of Fame who does not have a portrait in the Old Capitol building.

Because it is customary and proper that a portrait be placed there in recognition and honor of his extraordinary devotion to his profession and the people of Mississippi the Mississippi State Medical Association joins the Mississippi Public Health Association in a campaign to raise the funds necessary to commission a suitable portrait of Dr. Felix J. Underwood that would be displayed with the other Hall of Fame members in the Old Capitol building.

You will be hearing more about the campaign next month in the **JOURNAL MSMA**. In the meantime, if you would like to know more about the project or would like to make a financial contribution please contact Dr. Al Rausa, telephone number (601) 453-4563 or Dr. Alton Cobb (601)948-8894 respectively.

## MSMA Alliance

### MSMA Alliance Celebrates 1999-2000



The Alliance partnered with the Association to feature acclaimed authors Wayne Sotile, Ph.D. and Mary O. Sotile, M.S. as dinner speakers. Their topic was "Managing the Stress of Medical and Personal Relationships."

Your Alliance met in Biloxi, MS, May 13-16, 1999 for its 76th Annual Session. Guests were Susie Reeder, AMA Alliance representative and Jeanny Kalaycioglu, President, SMA Auxiliary. During the MSMAA House of Delegates meeting, reports were given and awards were received by Alliances in Membership, Health, AMA Foundation, and Legislation. The Outstanding Alliance Member for 1999 Award was presented to Susan Pichard of Central Alliance for her work in the area of Legislation.

The Alliance partnered with the Association to feature Wayne Sotile, Ph.D. and Mary O. Sotile, M.S. as dinner speakers. Their topic was "Managing the Stress of Medical and Personal Relationships." They "played" to an overflow crowd.

Mary Helen Schaeffer, wife of Dr. Phillip Schaeffer, was installed by Susie Reeder as 1999-2000 president.



Dr. and Mrs. Phillip Schaeffer (Mary Helen) following her installation as President, MSMA Alliance.



Susie Reeder, AMA Alliance; Dewitt G. Crawford, M.D. and Merrell Rogers, President-Elect, SMA Auxiliary.



*Dr. H. Allen Gersh and MSMA Alliance Past-President Cathy Gersh. It was a very successful year.*



*1999-2000 MSMA Alliance President Mrs. Phillip Schaeffer (Mary Helen) of Gulfport places a bid to benefit the AMA Foundation.*



*W. Briggs Hopson, Jr., M.D., 1999-2000 MSMA President, addressed the MSMA Alliance House of Delegates.*



Dr. and Mrs. Ralph L. Brock, Dr. and Mrs. Max L. Pharr, and Dr. and Mrs. John M. Estess examine their "quality purchases" at the AMA Foundation Silent Auction.



Martha Clippinger (not pictured) led Alliance members on a tour of Beavor to bring support of the need to establish a medical exhibit in context with the hospital and its medical history. [More to come on this plan.—Ed.]



**Left:** (1 to r) Jane Ladner, Parliamentarian; Sharron Guild, Treasurer; Denita Horne, Second Vice President Health Promotions; Susan Pichard, Fourth Vice President, Legislation; Mary Jane Wooten, Third Vice President, AMA Foundation; Ann Hopper, President-Elect; and Mary Helen Schaeffer, President are the 1999-2000 officers for the MSMA Alliance. Not pictured are: Kim Reed, First Vice President, Membership and Angela Ladner, Recording Secretary.

**Below:** A. Wallace Conerly, M. D., Vice Chancellor, UMC; Michael E. Jabaley, M. D.; Peggy Crawford, S.

Randall Easterling, M. D. and Dewitt G. Crawford, M. D., visit during the Medical Chapter of the University of Mississippi Alumni Association Reception and Annual Meeting reception.



## New Members

**BENTON, DAMEA B.**, Hattiesburg. Born August 10, 1965, Ft. Benning, GA; MD University of Mississippi School of Medicine, Jackson, MS, 1992; pediatric residency, University Medical Center, Jackson, MS, 1992-95; elected by South MS Medical Society.

**BENTON, LOUIS W.**, Hattiesburg. Born August 26, 1966, Jackson, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1992; ob-gyn residency, University Medical Center, Jackson, MS, 1992-96; elected by South MS Medical Society.

**BERGMANN, CHRISTOPH A.**, Tupelo. Born Buffalo, NY, April 18, 1961; MD State University of New York Health Science Center at Syracuse College of Medicine, Syracuse, NY, 1994; diagnostic radiology residency, Indianapolis, IN, 1994-98; musculoskeletal fellowship, Winston-Salem, NC 1998-99; elected by Northeast MS Medical Society.

**CARROLL, SARAH K.**, Pascagoula. Born Birmingham, AL, August 6, 1954; MD University of Alabama School of Medicine, Birmingham, AL, 1989; radiology residency, University of Alabama Medical Center, Birmingham, AL, 1989-93 and Univ. of Texas Southwestern Medical Center, Dallas, TX, 1993-94; elected by Singing River Medical Society.

**CHARD, DANA A.**, Laurel. Born Columbus, OH, April 15, 1968; MD Medical University of South Carolina College of Medicine, Charleston, SC, 1994; radiology residency University of Mississippi

Medical Center, Jackson, MS, 1994-1998; elected by South MS Medical Society.

**CONFORTI, JOHN F.**, Jackson. Born Brooklyn, NY, November 11, 1963; MD Southeastern College of Osteopathic Medicine, Miami, FL, 1989; interned one year, Humana Hospital of the Palm Beach; internal medicine residency Tulane University Medical School, New Orleans, LA, 1990-93; pulmonary & critical care fellowship, Same, 1990-93; elected by South MS Medical Society.

**EDMONSON, JAMES D.**, Corinth. Born Baton Rouge, LA, November 20, 1963; MD The University of Tennessee College of Medicine, Memphis, TN 1992; general surgery residency, University Medical Center & Veterans Adm. Hospital, Jackson, MS, 1992-98; elected by Northeast MS Medical Society.

**FAWZI, FAWAR**, Wiggins. Born May 29, 1945, Lebanon; MD St. Josephs French Faculty of Medicine, Beirat, Lebanon 1971; general surgery residency, Appalachian Regional Medical Center, Beckley, WV 1976-79; elected by South MS Medical Society.

**GIBSON, MICHELLE J.**, Greenville. Born May 27, 1969 in Mississippi; MD University of Mississippi School of Medicine, Jackson, MS, 1995; pediatric residency, University Medical Center, Jackson, MS, 1995-98; elected by Delta Medical Society.

**GLENN, CLYDE E.**, Cleveland. Born December 20, 1963; MD The

University of Iowa College of Medicine, Iowa City, Iowa, 1990; psychiatry residency, Ohio State University Medical Center, Columbus, OH, 1990-94; elected by Delta Medical Society.

**HALINSKI, DAVIDM.**, Vicksburg. Born Chicago, IL, September 6, 1956; MD University of Arkansas School of Medicine, Little Rock, AR, 1986; internal medicine residency, Same, 1988-1991 & pulmonary/critical care fellowship, same, 1991-94; elected by West MS Medical Society.

**HENDERSON, CHARLES A.**, Hattiesburg. Born Flint, Michigan, June 16, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; anesthesiology residency, Tulane Medical Center, New Orleans, LA, 1992-95; elected by South MS Medical Society.

**HERMAN-GORRONDANA, MARIA O.**, Gulfport. Born Guatemala, March 27, 1964; MD University Francisco Maroquin, Fac de Med, Guatemala; internal medicine residency, University of Mississippi School of Medicine, Jackson, MS, 1995-98; elected by Coast Counties Medical Society.

**HOLLABAUGH, ROBERT STERLING, JR.**, Southaven. Born Shelby Co, TN, July 21, 1966; MD University of Tennessee College of Medicine, Memphis, TN, 1992; general surgery residency, Univ. of Tennessee Medical Center, Memphis, TN, 1992-94 & urology residency, same, 1994-98; elected by Desoto County Medical Society.

**HOLLAND, MAUREEN S.,** Gulfport. Born San Bernardino, CA, May 22, 1962; MD Rush Medical College, Chicago, IL, 1988; pediatric residency Keesler AFB, Keesler, MS, 198-91; elected by Coast Counties Medical Society.

**HORN, GREGORY W.,** Ocean Springs. Born Arcadia, LA, June 22, 1964; MD Louisiana State University School of Medicine, Shreveport, LA, 1993; ob-gyn residency, same, 1993-97; elected by Singing River Medical Society.

**KYZAR, KENT C.,** Yazoo City. Born May 6, 1953, Brookhaven, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1984; family practice residency, Medical Center of Central Georgia, Macon, GA, 1984-87; elected by Delta Medical Society.

**LEWELLEN, THOMAS L., JR.,** Greenville. Born Arkadelphia, AR, January 1, 1968; DO Chicago College of Osteopathic Medicine, Downery Grove, IL, 1994; ob-gyn residency, Garden City Hospital, Garden City, MI, 1995-99; elected by Delta Medical Society.

**LORIO, D'ETTE E.,** Ocean Springs. Born Baton Rouge, LA, September 1, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1993; pediatric residency, University of Arkansas Medical Sciences, Arkansas Childrens Hospital, Little Rock, AR, 1993-96; elected by Singing River Medical Society.

**LYNN, CHRISTOPHER SCOTT,** Hattiesburg. Born Birmingham, AL, December 26, 1968; MD Medical College of Georgia, School of Medicine, Au-

gusta, GA, 1995; neurology residency, same, 1995-98; elected by South MS Medical Society.

**MAZZEO, JOHN T.,** Vicksburg. Born Newburgh, NY, January 11, 1945; MD New York Medical College, New York City, NY, 1970; general surgery residency, New York City, 1970-72 and Bethesda, Maryland, 1974-78; elected by West MS Medical Society.

**MENENDEZ, CHARLES V.,** Ocean Springs. Born New Orleans, LA, February 6, 1962; MD Tulane University School of Medicine, New Orleans, LA, 1988; radiology residency, Tulane Medical Center, New Orleans, LA 1990-94; elected by Singing River Medical Society.

**MITCHELL, CARLA L.,** Tylertown. Born Natchez, MS, July 9, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family practice residency, University of Mississippi Medical Center, Jackson, MS, 1994-97; elected by South Central Medical Society.

**MUNGAN, NILS K.,** Jackson. Born Canada, October 25, 1967; MD University of Ottawa Medical School, Ottawa, Ont., Canada, 1992; ophthalmology residency, Ochsner Clinic, New Orleans, LA, 1994-97; pediatric ophthalmology fellowship, The Hospital for Sick Children, Toronto, Canada, 1997-98; elected by Central Medical Society.

**PAPIZAN, CHERIE,** Hattiesburg. Born Lakenheath, England, September 4, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1996; internal medicine residency, University Medical Center, Jackson, MS,

1996-99; elected by South MS Medical Society.

**POLLES, ALEXANDRIA,** Hattiesburg. Born Clarksdale, MS, September 25, 1953; MD Tulane University School of Medicine, New Orleans, LA, 1981; emergency medicine intern, LSU Medical Center, New Orleans, LA, 1984; psychiatry residency, University Medical Center, Jackson, MS, 1990-93; addictionology fellowship, Pine Grove, Hattiesburg, MS, 1988; research, National Institute on Aging - NIH, Bethesda, MS, 1995; elected by South MS Medical Society.

**RASMUSSEN, GAIL E.,** Meridian. Born New York City, NY, October 7, 1956; MD University of Miami School of Medicine, Miami, FL, 1987; interned one year, St. Elizabeth's Hospital, Massachusetts, 1988; anesthesiology residency, Yale-New Haven Hospital, New Haven, Conn., 1988-91; fellowship pediatric anesthesiology, The Hospital for Sick Children, London, England; elected by East MS Medical Society.

**RICHARDSON, JOHN DAVID,** Jackson. Born Hazlehurst, MS, September 14, 1955; MD University of Mississippi School of Medicine, Jackson, MS, 1986; psychiatry residency, Baylor College of Medicine, Houston, TX, 1986-90; elected by Central Medical Society.

**ROBERTS, VICTORIA M.,** Pascagoula. Born Key West, FL, February 25, 1969; MD University of Miami School of Medicine, Miami, FL, 1995; internal medicine residency, Louisiana State University Medical Center, New Orleans, LA, 1995-98; elected by Singing

River Medical Society.

**SAMMS, CHARLES G.**, Gulfport. Born Mobile, AL, April 25, 1955; MD University of Mississippi School of Medicine, Jackson, MS, 1987; pediatric residency, Children's Hospital at Sacred Heart, Pensacola, FL, 1987-90; elected by Coast Counties Medical Society.

**SAWYER, DONALD E.**, Pascagoula. Born Cambridge, MA, September 11, 1944; MD New York Medical College, New York, NY, 1970; urology residency, La Hey Clinic, Burlington, NH, 1972-75; elected by Singing River Medical Society.

**SCANLON, PAT H.**, Jackson. Born Jackson, MS, May 8, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1994; surgery internship, Caraway Methodist Medical Center, Birmingham, AL, 1994-95 and surgery residency, same, 1995-99; elected by Central Medical Society.

**SIMPSON, JERRY G.**, Hattiesburg. Born Atlanta, GA, November 4, 1938; MD Medical College of Georgia, Augusta, GA, 1965; preventative medicine residency, Texas Dept. of Health, Austin, TX, 1972-75; fellowship public health, University of Texas School of Public Health, Houston, TX, 1972-73; elected by South MS Medical Society.

**SMITH, BOBBY H.**, Ecru. Born Virginia, November 14, 1967; MD East Tennessee State University School of Medicine, Johnson City, TN, 1994; pathology internship, Ohio State University Medical Center, Columbus, Ohio, 1994-95;

internal medicine residency, East TN University Medical Center, Johnson City, TN, 1995-98; elected by Northeast MS Medical Society.

**STOREY, JOANNA M.**, Jackson. Born Cleveland, OH, February 3, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1995; pediatric residency, Massachusetts General Hospital, Boston, MA, 1995-98; elected by Central Medical Society.

**SULTAN, KEITH S.**, Greenville. Born Nassau Co., NY, May 26, 1968; MD State University of New York at Stony Brook Health Science Center, Stony Brook, New York, 1994; radiation oncology residency, St Barnabas Hospital, Livingston, New Jersey, 1994-96; internal medicine residency, Lenox Hill Hospital, New York, New York, 1996-99; elected by Delta Medical Society.

**SHURE, DEBORAH**, Jackson. Born Albert Einstein College Medicine, New York City, New York, 1973; interned one year, Bellevue, New York University, New York, NY; internal medicine residency, Bellevue, NYU, New York, NY, 1974-77; pulmonary residency, University of California Medical Center, San Diego, CA, 1977-80; pulmonary fellowship, University of California Medical Center, San Diego, CA 1977-80; elected by Central Medical Society.

**SURRETT, RACHEL SIMMONS**, McComb. Born Magnolia, MS, April 14, 1967; MD University of Mississippi School of Medicine, 1993; radiology residency, University of MS Medical Center, Jackson, MS, 1993-97; elected by

South Central Medical Society.

**THORNTON, JON D.**, Hattiesburg. Born Columbia, LA, March 15, 1966; MD University of South Alabama College of Medicine, Mobile, AL, 1994; internal medicine residency, University of South Carolina Medical Center, Charleston, SC, 1994-97; renal fellowship, University of Mississippi School of Medicine, Jackson, MS, 1997-99; elected by South MS Medical Society.

**THORNTON, STANLEY N.**, Hattiesburg. Born Enterprise, AL, September 30, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1996; internal medicine residency, University Medical Center, Jackson, MS, 1996-99; elected by South MS Medical Society.

**WADE, TARENCE E.**, Greenville. Born Hollandale, MS, January 29, 1965; MD University of Iowa School of Medicine, Iowa City, IA, 1992; family practice residency, Des Moines Medical Center, Des Moines, IA, 1992-95; elected by Delta Medical Society.

**WEGENER, ERIC E.**, Jackson. Born Clarksdale, MS, October 26, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1992; surgery residency, University Medical Center, Jackson, MS, 1993-96; plastic surgery residency, Summa Health Systems, Akron, OH, 1996-98; hand fellowship, University Medical Center, Jackson, MS, 1998-99; elected by Central Medical Society.

**YOUNG, D RUSSELL**, Jackson. Born Oxford, MS, December 11, 1965; MD University of Mississippi School of Medicine, Jackson,

## Personals

MS, 1993; internal medicine internship & residency, University Medical Center, Jackson, MS, 1993-1996; elected by Central Medical Society.

### DEATHS:

**CROUCH, WILLIAM L.**, Jackson. Born Wren, MS, April 1, 1919; MD University of Pennsylvania Medical School, Philadelphia, PA, 1945; interned one year, U. S. Naval Hospital, Philadelphia, PA; ob-gyn residency, Ochsner Clinic, New Orleans, LA, 1949-53; ob-gyn fellowship, Tulane University Medical Center, New Orleans, LA, 1953; died February 4, 1999, age 80.

**HERRING, EMMETT M.**, Hattiesburg. Born Forrest County, MS, September 17, 1922; MD University of Illinois College of Medicine, Chicago, IL, 1947; interned one year, Charity Hospital, New Orleans, LA; ophthalmology residency, Tulane University Medical Center, New Orleans, LA, and EENT residency, Memphis EENT Hospital, Memphis, TN, 1953-56; died June 23, 1999, age 76.

**W. Lamar Weems, M.D.**, of the Mississippi Urology Clinic in Jackson, received the American Urological Association Gold Cane Award which honors a senior urologist who has made outstanding contributions to the profession and the American Urological Association. With approximately 13,000 members worldwide, the American Urological Association is the largest and most prestigious medical organization in the world dedicated to improving the prevention, diagnosis, treatment, and management of genitourinary disorders.

**Walter C. Gough, M.D.**, was elected president of the Mississippi Chapter of American College of Emergency Physicians, the first minority leader of a medical specialty in the history of Mississippi. Dr. Gough, an African-American, has been a member of ACEP for 20 years and works as an emergency physician at North Sunflower County Hospital, a rural hospital in Ruleville. He also has worked in private practice in Drew since 1984. He received his medical degree at Meharry Medical School in Nashville, Tennessee and completed his internship at Mercy Hospital in Pittsburgh. Dr. Gough also completed a residency in an-

esthesiology at Mercy Hospital and a residency in pediatrics at Hubbard Hospital in Nashville. He is board certified in emergency medicine and is eligible for board certification in pediatrics. Dr. Gough served as secretary/treasurer of the Mississippi Chapter of ACEP from 1995 to 1999. In 1989, he was elected to the Board of Trustees of The Christian Medical Society. He is married and has six children and seven grandchildren.

**C. Ralph Daniel, Jr., M.D.** announced his retirement from the practice of internal medicine. Dr. Daniel's practice will be continued by Central Medical Clinic, P.A., in Jackson.

**Thomas Lehman, M.D.** has accepted the position of Medical Director of Outpatient Rehabilitation at Delta Regional Medical Center. Dr. Lehman is a fellow of the American College of Cardiology and a member of the American College of Physicians. Dr. Lehman received an ABIM Special Certification in cardiovascular diseases and internal medicine.

**Gary H. Jackson, M.D., J.D.** of Hattiesburg has joined the firm of Bryan, Nelson, Randolph & Weatherers, P.A., Attorneys at Law. Dr. Jackson is a graduate of the University of Mississippi School of Medicine and completed his internship and residency at the University of Texas Health Science Center in San Antonio, Texas. He obtained his juris doctorate degree from Mississippi College School of Law.

**Robert J. Cole, M.D.** has retired from the practice of general surgery.

**Michael D. Fromke, M.D.** of Petal recently taught hands-on training courses using the StealthStation system in Mexico City. Dr. Fromke, a Hattiesburg Clinic neurosurgeon, taught microendoscopic diskectomy along with a course on cranial and spinal surgical applications of frameless stereotactic techniques. He will teach courses in China, Brazil, Venezuela and Argentina. The program was designed to educate neurosurgeons and orthopedic surgeons about minimally invasive surgery techniques. Dr. Fromke introduced computer-assisted frameless stereotactic surgery through image guidance and real-time navigation to the Hattiesburg area in 1997.

## Information and Quality Health Care

August marks the month beginning the historic Sixth Scope of Work implemented by I.Q.H. Meetings were held in July to inform our contacts and collaborators about the details of this new Health Care Financing Administration contract.

For anyone interested in the content of these meetings, they were videotaped. The latest information will be printed in **Quality Matters**, the I.Q.H. newsletter. Highlights of the meetings included discussion of the Health Care Quality Improvement Program with the quality improvement projects and the Payment Error Prevention Program.

The I.Q.H. board of directors is now in a transition over the next three years so that in the third year we will have 15 directors with three-year terms.

Officers have been elected for next year and include Dr. Mary Gayle Armstrong serving as chairperson; Dr. Glenn Peters, vice-chair; Dr. George Abraham, treasurer; and Dr. John Cook and Dr. Kenneth Reid, members at large. William Oliver, the administrator of Forrest General Hospital, Hattiesburg, is also serving on the executive committee.

The annual meeting of the membership required by our bylaws is scheduled when the full board of directors convenes September 22. The board will meet at 2:30 p.m., with the annual meeting scheduled an hour earlier.

### Quality Resource Available

An Internet-based source of information on clinical care that will assist health professionals to improve the

quality of care they provide to their patients has been announced by HHS Secretary Donna E. Shalala.

The National Guideline Clearinghouse (NGC) [www.guideline.gov](http://www.guideline.gov) is a new online service giving clinicians free and easy access to the latest health care practices from many sources, according to Secretary Shalala.

Thousands of clinical practice guidelines have been created by numerous organizations, which makes it difficult for clinicians to gain access to a full range of guidelines and then identify which guidelines are evidence-based. There has been no efficient way of making comparisons to select guidelines which best meet the clinician needs.

The NGC now responds to a long-standing need by identifying and featuring evidence-based clinical practice guidelines presented with standardized abstracts and tables that allow for comparison of guidelines on similar topics.

More than 500 clinical practice guidelines have been submitted to the NGC by physicians specialty groups, medical societies, managed care plans, state and federal organizations, as well as others. The NGC criteria for selecting evidence-based guidelines were published in a Federal Register notice on April 13, 1998. Operated by the Department of Health and Human Services, Agency for Health Care Policy and Research (AHCPR) in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP), the National Guideline Clearinghouse will continue to receive guideline submissions on an ongoing basis. The guidelines are intended for professionals and providers to

consider. They identify and describe generally recommended courses of intervention, but are not presented as a substitute for the advice of a physician or other knowledgeable health care professional or provider. Individual patients may require different treatments from those specified in a given guideline. Guidelines must be applied based on individual patient needs using professional judgment.

*The Agency for Health Care Policy and Research operates and maintains the NGC pursuant to statutory mandates: To support research designed to improve the quality of health care, reduce its cost, and broaden access to essential services; and to develop and disseminate evidence-based information to increase the scientific knowledge needed to enhance patient and clinical decision-making, improve health care quality, and promote efficiency in the organization of public and private systems of health care delivery. Authors and publishers are identified at the beginning of each document.*

— James S. McIlwain, M.D., President

*The Mississippi State Medical Association  
requests the pleasure of your company*

*at the dedication of our  
new headquarters building*

*followed by an  
Open House*

*on Friday the 13th of August, 1999  
from 3 p.m. until 6 p.m.*

*408 West Parkway Place  
Ridgeland, Mississippi*

## FINANCIAL RESOURCES

TAILORED TO FIT ONE SET  
OF GOALS AND OBJECTIVES.

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# Placement / Classified Service

**Journal MSMA Placement ads** are \$2.50/line, with a 5-line minimum charge of \$12.50. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing. Items should be sent to:  
**Placement Service,**  
**Journal MSMA,**  
**PO Box 5229,**  
**Jackson, MS, 39296-5229, or**  
**Fax to: 601/352-4834**

**Journal MSMA Display Classified ads** 1x insertion cost \$115.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge. Items should be sent to:  
**Classified Section,**  
**Journal MSMA,**  
**PO Box 5229,**  
**Jackson, MS, 39296-5229, or**  
**Fax to: 601/352-4834**

## PHYSICIANS NEEDED

Physicians (especially specialists such as cardiologists, ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office.

WATS 1-800-962-2230  
Jackson, 853-5487  
Leola Meyer (Ext.5487)



**Disability Determination Services**  
**1-800-962-2230**

## PART-TIME PHYSICIANS

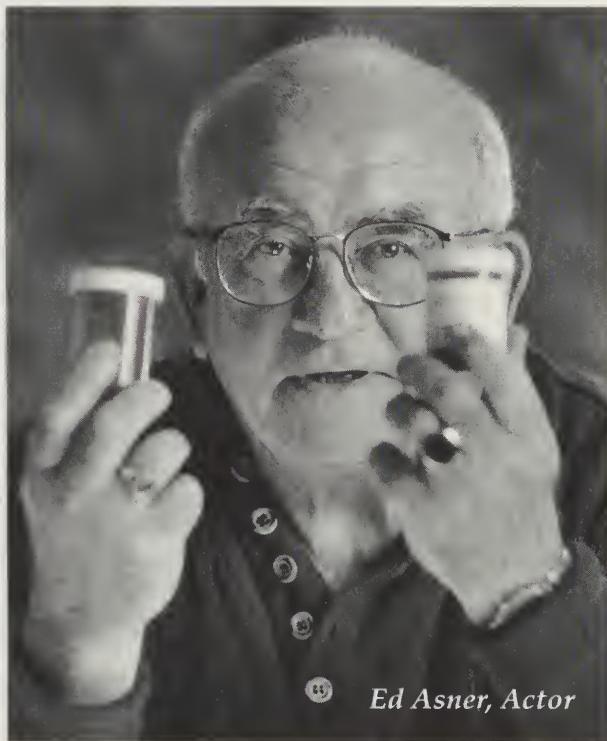
M.D. to serve on a part-time basis to perform entrance level physical examinations for military applicants. 601-355-3645.

## MEDICAL PHYSICIAN WANTED

Mississippi - Seek board certified/board eligible Internal Medicine physician to live and work in an underserved area. Fax CV with your criteria in confidence to 504-649-1217.

*Although the Journal MSMA believes the advertisements in this issue to be from reputable sources, it does not investigate the offers made and assumes no liability concerning them. The Journal MSMA reserves the right to decline, withdraw, or modify advertisements at its discretion. Publication of any ad should not be deemed an endorsement of the products or services advertised.*

# Attention: Physicians



## Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

*"What other prescription and nonprescription medicines are you taking?"*

**YES!** Please send me free information to use when talking with my patients about their multiple medicine use.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zipcode \_\_\_\_\_

Mail to:

NCPIE  
666 Eleventh Street, NW  
Suite 810  
Washington, DC 20001

OR FAX:  
(202)638-0773

## MISSISSIPPI STATE MEDICAL ASSOCIATION

# Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

### MEMBERSHIP HOTLINE

The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

### MEDICAL OFFICE SUPPLIES

MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

### THIRD PARTY PAYOR LIAISON

MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

### HEALTH INSURANCE

MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

### WORKERS' COMPENSATION INSURANCE

The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Gusta Stanford at MPIC.

### PRACTICE MANAGEMENT

Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts

practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

### DEBT COLLECTION SERVICE

Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

### INSURANCE/FINANCIAL/RETIREMENT PROGRAM

MSMA members have available several insurance plans designed exclusively for physicians. Through the "group" buying power of the association the plans can usually be obtained at lower cost and there is the advantage of "one stop" coverage. For further information contact Executive Planning Group.

### MEDICAL MALPRACTICE INSURANCE

The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. The Company currently has 2000 policy holders. Extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services -  
P. O. Box 2548, Ridgeland, MS 39158-2548  
(601) 853-6733 or 800-898-0251 (In-State-WATS).

AMA Purchase Link - 800-772-4346.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company -  
P. O. Box 2548, Ridgeland, MS 39158-2548  
(601) 853-6733 or 800-898-0251 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-2000 or 800-325-4172 (In-State-WATS).

Executive Planning Group, P. A. - 601-982-3000 or 800-898-0954 (In-state-WATS).

## MISSISSIPPI STATE MEDICAL ASSOCIATION

# Membership Services

**When you need information on a specific subject or association service,  
the following MSMA staff person(s) are available to assist you.**

**Address Changes** • Barbara Shelton

**Advertising** • Karen Evers

**Alliance Activities** • Barbara Shelton

**Annual Meeting:**

**Delegates** • Barbara Shelton

**Scientific Exhibits** • Karen Evers

**Technical Exhibits** • Alicia Thame

**Meeting Schedule** • Karen Evers

**Bills and Invoices** • Dominica Thame

**Board of Trustees & Officers** • Bill Roberts

**Complaints from the Public/ Peer Review**

• Lora Lane

**Continuing Medical Education** • Lora Lane

**Component Medical Societies** • Barbara Shelton

**CPT/ICD-9 Inquiries** • Debra Collins

**Directories (MSMA and Alliance member**

**listings)** • Barbara Shelton

**Dues (MSMA & Alliance)** • Barbara Shelton

**Health Care Statistics and Data** • Jackye Wiebelt

**Hospital Medical Staff Matters** • Linda McMullen

**Insurance Form Orders** • Deborah Miranda

**Journal MSMA** • Karen Evers

**Legislative Activities** • Charmain Thompson

/Linda McMullen

**Licensure** • Linda McMullen

**Mail Lists & Labels** • Deborah Miranda

**Media (Radio, TV, Press)** • Karen Evers

**Medical Ethics** • Linda McMullen

**Medical Student Membership** • Barbara Shelton

**Medicare/Medicaid/Third Party Payors** • Jackye Wiebelt

**Member Insurance Programs** • Jackye Wiebelt

**MMPAC/AMPAC** • Charmain Thompson

**MS Physicians Care Network** • Dave Strelein

**MS Physicians Insurance Co.** • Gusta Stanford

**Physician Referrals** • Lora Lane

**Practice Management Workshops** • Debra Collins

**Public Information** • Karen Evers

**Resident Physician Membership** • Barbara Shelton

**Specialty Society Services** • Barbara Shelton

**State/Federal Government** • Charmain Thompson  
/Linda McMullen

**X-Ray Technician Training** • Alicia Thame

**Young Physician Section** • Linda McMullen

### MSMA Office

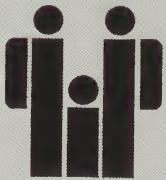
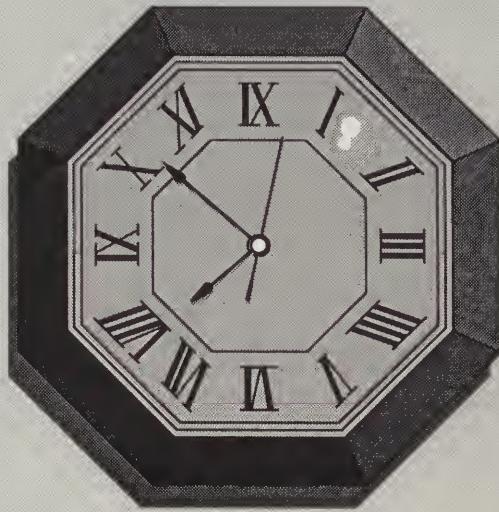
**408 West Parkway Place  
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# **Skin Necrosis Induced by Extravasation of Glycerol-Containing Peripheral Parenteral Nutrition Formulation**

Gordon S. Sacks, PharmD

Tara L. Mir, PharmD

Makau Lee, MD, PhD

## **A**STRACT

Administration of parenteral nutrition (PN) via a peripheral vein has gained support over the last decade due to serious complications associated with central venous catheterization. Extravasation and tissue necrosis have been reported with both peripheral and central dextrose-containing PN formulations. The following case report represents the first documented case of skin necrosis due to extravasation of a glycerol-containing PN formulation. Our patient's condition resolved with local therapy such as elevation of the affected extremity and cold compresses. Routine evaluation of proper catheter placement is recommended to prevent this serious morbid event, while various treatment recommendations are outlined for severe injuries that do not respond to general measures such as cold compresses.

**Key words:** skin necrosis,  
extravasation,  
peripheral parenteral nutrition.

## **INTRODUCTION**

Administration of parenteral nutrition (PN)

via a peripheral vein has gained support over the last decade due to serious complications associated with central venous catheterization. Pneumothoraces, cardiac perforations, venous thromboses, and catheter-related infections associated with central venous catheters have persuaded practitioners to increase the use of peripheral PN in the institutionalized setting.<sup>1</sup> New developments in catheter materials such as silicone elastomer and macronutrient substrates like glycerol have also reduced the incidence of thrombophlebitis occurring with peripheral PN. Despite its advantages, peripheral PN is not without its limitations. Extravasation and tissue necrosis have been reported with both peripheral<sup>2</sup> and central<sup>3</sup> dextrose-containing PN formulations. The purpose of this report is to increase physician awareness of potential cutaneous complications induced by extravasation of peripheral PN formulation. Potential etiologies, sequelae, prevention strategies, and treatment recommendations for extravasation of PN formulation are reviewed.

## CASE REPORT

An 82-year-old African-American man developed a pressure ulcer on his left heel while residing in a long-term care facility. The ulcer was not healing appropriately due to the patient's poor nutritional status. Increased caloric and protein intake had been attempted with oral supplements, but this method failed to consistently meet the patient's estimated nutritional needs. Provision of enteral nutrition via a small-bore nasoenteric feeding tube or percutaneous endoscopic gastrostomy tube was refused by the patient. Because the pressure ulcer had progressed to Stage 3, the delivery of nutrition by the parenteral route was offered to the patient. He agreed to the administration of a glycerol-containing PN formulation (ProcalAmine®, B. Braun Medical Inc., Irvine, CA, via a short peripheral catheter inserted in his forearm at a rate of 83 mL/hr). Extravasation of

the PN formulation occurred on the evening of the 4th day of PN administration, but was not discovered until the next morning (i.e., day 5 of PN administration). The patient developed pain and swelling in his forearm, followed by blister formation and skin denudement at the catheter site (see Figure 1). The patient was diagnosed with skin necrosis due to PN extravasation. The peripheral intravenous catheter was removed immediately, and PN was discontinued. Treatment for the next 3 days included cold compresses applied to the affected area and elevation of the injured arm. For relief of pain and inflammation, hydroxyzine and meperidine were given intramuscularly as needed. The local edema and inflammation resolved gradually over the next 7 days, while the denuded area (due to rupture of the blisters) healed without significant sequelae.

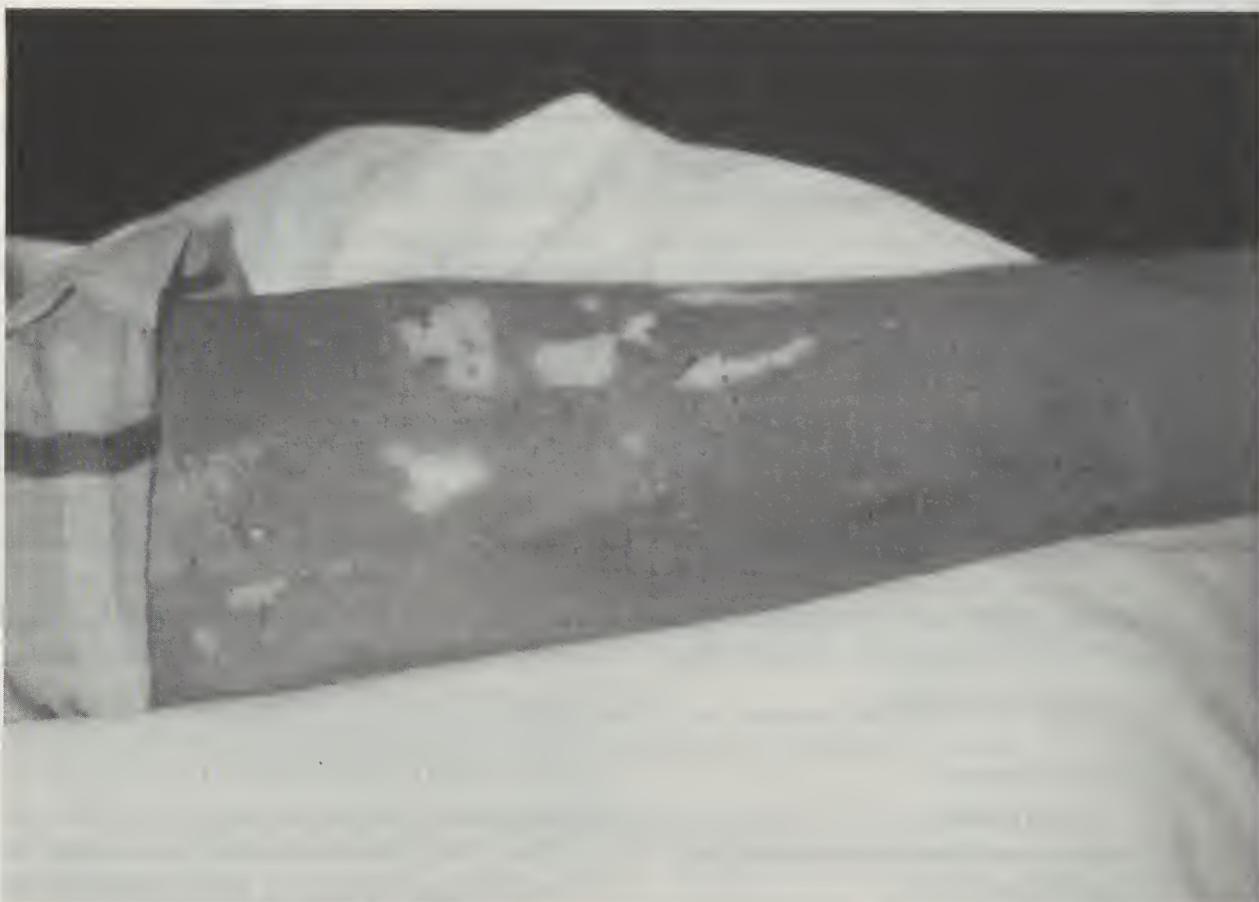


Fig 1.— Picture of the patient's forearm showing skin denudement (after rupture of blisters) and edema at the site of extravasation; this picture was taken 24 hours after extravasation.

## DISCUSSION

Although extravasation of cytotoxic agents is a fairly common problem, reports of PN extravasation have been sparse. Extravasation of peripheral PN formulations containing amino acids, dextrose and electrolytes has been reported to result in skin necrosis and damage to the underlying tendons, nerves, and joints<sup>1-3</sup>. To our knowledge, this is the first documented case of skin necrosis due to extravasation of a glycerol-containing PN formulation.

The mechanisms by which various components of PN cause tissue necrosis are poorly understood. Formulations with a high osmolality have been associated with tissue damage. Direct cell damage may occur from differences in osmotic forces after infiltration of hypertonic fluids. Continued administration of the fluid into a limited tissue space may cause ischemia and initiate a cascade of damaging events, such as decrease in pH, weakening of capillary walls, worsening edema, and cellular toxicity and death.<sup>2</sup> Given that the glycerol-containing PN formulation (ProcalAmine®, B. Braun Medical Inc., Irvine, CA) has a calculated osmolality of 735 mOsmol/L,<sup>4</sup> which is 2.5-fold greater than that of serum (281-289 mOsmol/L), tissue damage from hyperosmolality is a consideration in our patient.

Concentrated solutions of calcium and potassium have also been associated with skin necrosis following extravasation.<sup>5</sup> Readily dissociable salts of calcium, such as calcium chloride, are thought to be more injurious as they may precipitate proteins to cause direct cellular toxicity. Potassium chloride concentrates for injection can be acidic (pH as low as 4) and hypertonic, thus care must be taken to dilute this preparation prior to administration. The glycerol-containing PN formulation in our case contains potassium chloride 24 mEq/L and calcium acetate 3 mEq/L<sup>4</sup>. Although these concentrations appear to be low, the presence of these ions may have contributed to the tissue damage experienced by our patient. Infiltration of acidic solutions into perivenous tissue has been hypothesized to cause vasocon-

striction, leading to ischemia and necrosis.<sup>5</sup> The reported pH of the glycerol-containing PN formulation is 6.8 (range: 6.5-7).<sup>4</sup> This degree of acidity outside the physiologic range of 7.35-7.45 for human blood may have been an additional factor in our patient's injury.

A variety of techniques have been employed for the treatment of extravasation injuries. General measures include discontinuation of the infusion and elevation of the injured extremity to promote drainage.<sup>6</sup> Applications of heat or cold to the affected area have been reported as successful treatments for extravasation of antineoplastic agents. Heat will cause vasodilation and facilitate distribution and absorption of the offending agent. In contrast, cold will induce vasoconstriction and contain an irritant fluid in a localized area so that an antidote may be injected.<sup>6</sup> Cold compresses have also been recommended to limit the inflammatory response associated with such injuries. Although cold compresses were prescribed for our patient, the efficacy of routine heat or cold as treatment modalities for PN extravasation has not been systematically evaluated.

Corticosteroids have been utilized for a mitigating the pain and inflammation associated with extravasation. Intradermal and subcutaneous injections of hydrocortisone sodium succinate as well as topical hydrocortisone cream have been used with some success in the treatment of doxorubicin extravasation.<sup>7</sup> Injections of hydroxyzine and meperidine were administered to our resident for comfort care, but no literature substantiates the efficacy of this practice. Use of topical nitroglycerin has also been described in preventing serious tissue damage from extravasated PN solution in a neonate.<sup>8</sup> O'Reilly<sup>8</sup> et al. reported that a nitroglycerin patch releasing 5 mg per 24 hour was applied for one hour to a 2 x 3-cm area on the dorsum of the foot. The skin beneath the patch eventually healed without scarring, whereas full thickness skin loss occurred in areas not covered by the patch. The investigators suggested that nitroglycerin ointment may be an effective alternative to the patch for preventing skin necrosis in

difficult body areas, such as over joints.<sup>8</sup>

Other investigators have advocated prompt removal of the offending fluid while conserving the overlying skin.<sup>9,10</sup> This can be accomplished with two techniques: liposuction or saline flushout. Using a blunt-ended liposuction cannula, extravasated material with subcutaneous fat can be aspirated via subcutaneous tunnels.<sup>9</sup> In areas with little subcutaneous fat, subcutaneous injections of hyaluronidase 1500 units are used to hydrolyze the hyaluronic acid of connective tissues and facilitate subsequent fluid removal with saline flushout.<sup>10</sup> Four small incisions are made around the extravasation area and a Verres needle is used to inject 20-50 mL aliquots of saline to flush and cleanse the subcutaneous space. Both techniques should be conducted in sterile environments and the wounds should be covered with betadine-soaked gauze for 24 hours following the procedures.<sup>9,10</sup>

Subcutaneous injections of hyaluronidase<sup>11</sup> and chondroitin-sulfatase<sup>12</sup> have been used as sole treatment modalities for extravasation of dextrose-based PN formulations. Both are enzymatic spreading factors that depolymerize components of the tissue cement and promote separation of the tissue planes. The extravasated material is dispersed over a larger surface area, promoting rapid absorption and minimizing tissue injury. Intradermal or subcutaneous injections of hyaluronidase through a 25-gauge needle have been effective in treating PN extravasation.<sup>13</sup> A total dose of 15 units is recommended, administered in 5 separate injections into the extravasation site at the leading edge. When chondroitin-sulfatase has been administered, total doses of 150-200 turbidity-reducing units have been given in 6-8 injections around the inflamed area.<sup>12</sup> Although no adverse effects were reported in these cases, allergic reactions (i.e., urticaria) may occur rarely with either preparation.

Establishing safe practice guidelines for the administration of all intravenous therapy is the most important step in preventing necrotic complications from extravasation. Recommendations

include:<sup>6,12</sup> (1) proper selection and placement of intravenous cannulas (2) avoidance of the dorsum of the hand, lower extremities, and sites over tendons, nerves, and bony prominences, especially in elderly patients with preexisting vascular disease, (3) frequent monitoring of the cannula site for correct positioning and patency, and (4) maximal dilution of intravenous medications and appropriate infusion rates. By incorporating these measures into our daily practice, serious injuries from extravasation of hypertonic solutions, including glycerol-containing PN, may be avoided.

In conclusion, the primary care physician needs to be aware of potential cutaneous complications associated with peripheral PN administration. This case report describes one such patient and our patient's condition resolved with local therapy such as elevation of the affected extremity and cold compresses. Routine evaluation of proper catheter placement is recommended to prevent this serious morbid event, while various treatment recommendations are outlined for severe injuries that do not respond to general measures such as cold compresses.

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# Abstracts from the Mississippi American College of Physicians Associates' Meeting

*The following abstracts presented at the Mississippi American College of Physicians Associates' Annual Meeting represent the second of a three-part series to be published in subsequent issues of the JOURNALMSMA.*

—ED.

## Refractory Agranulocytosis in A Patient with Spindle Cell Thymoma

**Guangzhi Qu, M.D.**

**Carolyn Bigelow, M.D.**

**University of Mississippi Medical Center  
Jackson, Mississippi**

A 68 year old man with an unremarkable past medical history presented with persistent fever, a recurrent perirectal abscess and neutropenia. His symptoms persisted despite treatment with multiple antibiotics and surgical drainage. His initial CBC showed a white blood cell count of 900/FL with 4% neutrophils and 92% lymphocytes, a platelet count of 280,000/FL and a hemoglobin of 11.1g/dL. A search for the etiology of his neutropenia was initiated. All medications that could cause neutropenia were discontinued. Infectious etiologies were evaluated including a negative HIV antibody, negative hepatitis B surface antigen, RPR, monospot antibody, and negative Parvovirus B19 IgM level. His immunological findings showed a mildly positive rheumatoid factor, positive anti-nuclear antibody. A bone marrow biopsy revealed hypercellularity with absence of myelopoiesis. The erythroid series and megakaryocytes were increased. The chromosomal analysis of the bone marrow showed a predominant karyotype of (45, X, -Y). The patient's chest radiograph revealed evidence of an anterior mediastinal mass. Chest CT showed a large anterior mediastinal mass

with smooth margins. Marked splenomegaly was revealed on his abdominal CT. The mass was surgically removed and this revealed a benign spindle cell thymoma. Immunophenotyping of both his peripheral blood and thymic tumor revealed a predominant T-cell process. Bone marrow CFU-GM cultures were performed and the patient's serum failed to suppress myeloid colony formation, suggesting lack of antibody mediated agranulocytosis. The neutrophil level of this patient remained low despite multiple treatments, including G-CSF, GM-CSF, Cyclophosphamide, steroids, thymectomy and plasmapheresis. The patient died of overwhelming sepsis. In previous reports of neutropenia associated with thymomas, the treatments listed above have been shown to be effective. Agranulocytosis associated with thymoma is a very rare disease process, with only eleven cases identified in the literature. Our patient, as in two previously reported patients with thymoma-associated agranulocytosis, showed no myelopoiesis in the bone marrow. This seems to portend a fatal outcome.

## **Two Cases of Pulmonary Artery Rupture Complicating Swan-Ganz Catheterization**

Capt. Mark E. Campbell (ACP Associate)

Maj. Charles F. Botti, Jr., (ACP Member)

Maj. Matthew T. Carpenter (ACP Member)

Keesler Medical Center

Keesler Air Force Base, Mississippi

Critically ill patients may require invasive monitoring with Swan-Ganz (SG) catheters to optimize hemodynamics. Although usually safe, serious complications may occur if proper technique is not observed. Two recent cases at Keesler Medical Center illustrate this point.

**Case 1:** A 77 year old man was admitted with critical AS and suspected PE. On hospital day 12 worsening respiratory status required SG placement via right IJ approach. A 7½ French SG was floated to 50 cm obtaining a good wedge tracing. The balloon was deflated and cautiously reinflated to obtain PCWP measurement; the total duration of balloon inflation was < 60 seconds. This was followed by brisk hemoptysis of 50 cc over 5 minutes. The patient was emergently intubated. Hemoptysis subsided spontaneously and chest radiograph did not reveal an infiltrate. The etiology of PA rupture was presumed to be improper catheter positioning. He died 8 days later from causes unrelated to his hemorrhage.

**Case 2:** A 81 year old man was admitted with pneumonia, sepsis, and myocardial ischemia. On hospital day 10 worsening hemodynamics required 8 French SG placement via right IJ approach. 2 days later because of cordis occlusion the SG had to be replaced.

The new SG had to be repositioned once to obtain a good wedge tracing. The balloon was then cautiously inflated, but PCWP could not be measured. No unusual resistance was noted but the patient rapidly developed hemoptysis and died shortly after this. Autopsy showed the tip of the SG outside a small distal artery in the RML; this vessel had a 1 cm rupture. The etiology was presumed to be improperly supervised manipulation of the SG.

Fatal complications of SG catheterization may occur unless physicians observe meticulous technique at all times. Operator experience needs to be considered before SG catheterization is performed.

## **Heparin Associated Thrombocytopenia and Thrombosis Presenting as an Acute Myocardial Infarction**

Capt. Joshua A. King (ACP Associate)

Capt. D. Scott Harper (ACP Associate)

Maj. Anthony Jaslawski (ACP Member)

Maj. Daniel Carey, F.A.C.P.

81<sup>st</sup> Medical Group

Keesler Air Force Base, Mississippi

Anticoagulation with heparin is a standard treatment in thrombotic disorders. A small but significant proportion of patients receiving heparin develop heparin associated thrombocytopenia and thrombosis (HATT). These patients are at risk of serious thromboembolic complications including stroke and myocardial infarction. HATT is an antibody-mediated syndrome usually presenting 4 to 14 days following the initiation of heparin, but can occur sooner if there has been prior exposure to the drug.

A 57 year old woman presented two weeks after two-vessel coronary artery bypass surgery with 3 days of left leg swelling. Doppler ultrasound confirmed a proximal popliteal deep vein thrombosis (DVT), and intravenous heparin was started. Two hours after starting heparin she developed acute retrosternal chest pain with ECG changes consistent with acute inferior injury. Cardiac catheterization showed the graft supplying the inferior wall to be widely patent, with haziness suggesting thrombus in the native vessel. With repeated contrast injections, the haziness, ST-segment elevations, and chest pain resolved. The patient was continued on heparin following the catheterization, and coumadin therapy was initiated to treat her DVT. Over the next 3 days her platelet count progressively fell from 362,000 to 73,000. The clinical diagnosis of HATT was made, and the heparin was promptly discontinued. A two-point <sup>14</sup>C-scrotonin release assay and a platelet aggregation test were markedly positive for both standard porcine heparin and low molecular weight heparin (enoxaparin). The patient's platelet count rapidly returned to normal over the next 2 days.

Our hypothesis is that heparin-dependent anti-plate-

let antibodies were formed at the time of her cardiac surgery. Upon rechallenge with heparin, the patient developed prompt platelet aggregation and thrombosis at the site of competitive flow resulting in an acute myocardial infarction. Patients with prior exposure to heparin may develop rapid and life-threatening thromboembolic complications. Clinicians need to have a high index of suspicion for HATT in patients with sudden, new thrombosis after the administration of heparin.

## Satellite DNA Hypomethylation vs. Overall Genomic Hypomethylation in Ovarian Epithelial Tumors of Different Malignant Potential

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<sup>2</sup>Tulane Medical School, New Orleans, Louisiana

**Background:** Rearrangements in the heterochromatin in the vicinity of the centromeres of chromosomes 1 (Chr1) and 16 are frequent in many types of cancers, including ovarian epithelial carcinomas. Satellite 2 (Sat2) DNA is the main sequence in the unusually long heterochromatin region adjacent to the centromere of each of these chromosomes. Evidence suggested that hypomethylation of Sat2 DNA is associated with chromosomal rearrangements in these regions. Genome-wide hypomethylation is commonly detected in many types of cancers, including ovarian cancers.

**Purpose:** To determine if satellite hypomethylation correlates with degrees of malignant potentials and genome-wide hypomethylation in ovarian tumors with different malignant potentials.

**Methods:** DNA methylation levels were assessed by Southern blot analysis with DNA methylation-sensitive enzyme *Bst*B I and radiolabeled probes for Chr1 Sat2, Chr16 Sat2, and Chr1 Sat $\alpha$ . The levels of genome-wide DNA methylation were determined by HPLC.

**Results:** We analyzed DNA methylation status at juxtapacentromeric Sat2 and centromeric Sat $\alpha$  of Chr1 and Chr16 in ovarian carcinoma, low malignant potential (LMP) tumors, and cystadenomas. DNA from 6 of the 8 studies ovarian carcinomas showed appreciable hypomethylation. Moderate degree of hypomethylation in this satellite DNA was detected in 3 of the 5 LMP tumors. In contrast, none of 4 examined ovarian cystadenoma was hypomethylated in this sequence. There was a statistically significant linear trend between malignant potential and the degree of hypomethylation of Chr1 Sat2 DNA ( $P < 0.01$ ). The methylation status of Chr16 Sat2 was approximately the same as that of Chr1 Sat2 DNA in all of the ovarian tumors. However, such association did not apply to the centromeric Sat $\alpha$  DNA. We also demonstrated statistically significant linear trend between global DNA hypomethylation and Chr1 Sat2 hypomethylation ( $P < 0.005$ ).

**Conclusion:** We demonstrated a strong correlation between the degrees of malignant potentials of ovarian tumors and the levels of Chr1 Sat2 hypomethylation. Ovarian tumors with low overall genomic hypomethylation tended to be undermethylated Chr1 and Chr16 Sat sequences. Such relationships were not observed with Chr1 centromeric Sat $\alpha$  sequence.

**Future Directions:** Further research on the structural and numerical aberrations of Chr1 and Chr16 in ovarian cancer will help to clarify the relevance of the observed hypomethylation to karyotypic instability.

## Live & Then Give

*[At the 131st annual meeting, the House of Delegates adopted Resolution No. 5 which states "the MSMA will continue to work with organ and tissue recovery agencies of Mississippi to make certain that all citizens ... are offered the option of donation of solid organs and/or tissue as appropriate." The following is information from the AMA Live & Then Give campaign which you may find helpful. —Ed.]*

### Talking to Patients About Donation

According to a Gallup Poll, 80 percent of Americans express a willingness to donate organs, yet the nation has a shortage of available organs for transplantation. Experts believe that more people would agree to become donors if they were approached in a sensitive, caring manner.

Physicians can be a powerful and persuasive force in educating the public, especially their own patients. Because of the tremendous demands on their time, however, a physician may designate a staff person or allow an alliance member to speak to patients on the physician's behalf.

### Tips for Patient Education

- *Choose a non-crisis office visit.* Regular check-ups or follow-up visits are ideal times to discuss the possibility of becoming a donor. The patient is healthy, calm, and able to focus on a sensitive topic.

- *Make your role clear.* A nurse or volunteer who speaks to the patient needs to make it clear that he or she is speaking on the physician's behalf. "Dr. Jones has asked me to talk to all of our patients about a matter he feels strongly about."

- *Determine the patient's mood.* If the patient seems stressed or hostile to the topic, postpone the discussion to a later time.

- *Stress the positive.* Emphasize that transplan-

tation is one of the most remarkable success stories of modern medicine. Donating one's organs could end suffering and save lives of many seriously ill people.

- *Answer questions simply.* Refer to Frequently Asked Questions in this manual. Avoid medical jargon. If you don't know the answer, say so and refer the patient to your local OPO.

- *Provide a donor card.* Encourage the patient to take the card home and speak to family members that night.

- *Offer literature.* It's easy for everyone to forget details, and many of us don't think of a question until later. Having something to read and show others can help the patient answer questions from family members.

### Suggested Approaches

Find a way that feels most logical and comfortable for you to approach the subject of organ and tissue donation with patients. Some suggestions:

1. *Be a role model.* "I've recently told my family that if I die suddenly I want to be an organ and tissue donor. I'm so committed to my decision that I'm suggesting it to all our patients." Your candor and enthusiasm can encourage patients to begin thinking about a similar decision for themselves.

2. *Refer to recent media coverage.* "You may have heard something in the press about organ donation

and transplants. I'm concerned that our patients have the facts. Do you have any questions about that topic that I can help you with?" It may be difficult for patients to discuss donation in relation to themselves, but less difficult in relation to an event or news story.

**3. Mention the topic in relation to the patient's interests.** "I see from your T-shirt that you were in the charity run. If you're interested in fitness and charity, I think you might be interested in organ donation."

**4. Present the topic as a survey question.** "Are you a pledged organ donor? Would you like Dr. Jones to provide more information about how to become one?" The question can be included in the patient sign-up sheet or an evaluation form. The question could also be asked orally at the end of the visit: "We're surveying patients about organ donation. Are you a pledged donor, or are you interested in becoming one?"

## What to Expect

Some patients may be afraid to talk about donation because they associate it with death. You may be able to help them overcome their fear and discuss the issue openly. Be prepared for a variety of reactions.

**Anxiety.** If the patient becomes anxious, remain calm. Point out that the conversation is really about giving life to other human beings. If this positive approach does not work, respect the person's wish to end the conversation. Perhaps he or she will be able to discuss the subject at another time.

**Humor.** You may find that a patient will begin to make jokes about donation. Often this is a way to deal with his or her own anxiety about the issue. The humor may be a way to lighten the mood. This reaction is normal. You may choose to respond in kind: "Just think, you'll be able to say, I love you with my whole kidney." At some point, you will return to a serious tone, and the patient will follow your lead.

**Argument.** The patient may argue or express an opinion with which you disagree. Listen calmly, without judging. It is important to support each person's right to his or her individual point of view, especially on this most personal matter. Acknowledge the person's opinion. "You may be right, but I don't agree." Refrain from arguing back. You are looking for the 8 out of 10 people who want to be organ donors, not the two who don't.

**Silence.** The patient who says little or nothing can be frustrating because you don't know whether he or she

understands, agrees, or feels afraid. Instead of yes-no questions ("Do you understand?"), ask open-ended ones ("What do you think about becoming an organ donor?"). Acknowledge the silence: "You haven't said anything. I'd like to hear from you now." Offer to defer the discussion to another time: "Because you haven't said anything, I'm afraid I've upset you. Maybe we can talk about this later."

## Key Actions Needed

If a patient seems agreeable about becoming a donor, encourage him or her to do the following:

1. Discuss the decision with family members and next-of-kin. In the event of the patient's death, they will know that they are fulfilling his or her wishes.
2. Sign the donor card in the presence of two witnesses (preferably family members), and ask them to also sign it.
3. Place the signed card in your wallet.

## Why is Family Discussion Important?

If organs are to be transplanted, time is of the essence. Many steps must be taken to evaluate and preserve the organs, find a suitable match, transport them, and make arrangements for transplantation. Consent from the family is needed quickly.

If families have discussed their desires regarding donation before a death occurs, the burden of trying to make a major decision during a time of grief is lifted from their shoulders. Experience shows that most families find a great deal of comfort in organ and tissue donation. They feel that something positive has come from an otherwise tragic and meaningless event. This feeling of comfort is even stronger when they know, based on previous discussion, that their loved one supported the idea of donation.

Family discussion is also important because of misunderstandings surrounding donor cards and driver's licenses. A signature on a donor card or driver's license will not automatically result in donation if the situation arises. The one who actually will face this decision at the time of death is the deceased's family. This decision will be much easier to make when the family members know the wishes of their loved one.

## Confusion About Brain Death

Some studies show that most people understand and accept brain death, but are not fully aware of the relationship between brain death and organ donation. In particular, they do not know that in order to donate organs, a person must be pronounced brain dead.

In talking to patients, make it clear that **brain death is death, not a predictor of death**. It is the complete and irreversible cessation of all brain function. This means that the person is unable to breathe spontaneously, and has no memory, consciousness, knowledge, thought, feeling, sight, touch, or any other sense. The brain is irreparably destroyed and begins to deteriorate almost immediately.

Brain death usually occurs when a person receives a severe head injury, suffers a stroke, experiences bleeding into the brain, or has another event that deprives the brain of oxygen. With these types of injuries, patients are always placed on a mechanical ventilator for artificial ventilation.

If the injury is so severe that brain death is suspected, a physician will conduct a variety of specific tests to determine if there is any brain function. If the results indicate that no function remains, the patient is declared brain dead. The person may look as if he or she is asleep but, in fact, the personal, intellectual, and social characteristics that made that person an individual are gone. Without the mechanical ventilator, the person would not breathe and the heart would soon stop beating.

Shortly after the family members have been informed of their loved one's death, they will be given the opportunity to donate organs and tissue. If they agree, the ventilator that has artificially supplied oxygen to the patient stays activated in order to keep blood and oxygen flowing to the organs. Many people find this procedure hard to understand, but it is essential for successful organ donation.

Organs can be used for transplantation only if they are oxygenated and functioning up until the moment they are recovered from the donor. This is why donated organs must come from a person who is brain dead and whose organ function has been artificially maintained on a ventilator. Otherwise, the organs would not be suitable for transplant.

If the family members decide not to donate their relative's organs, the ventilator will be removed. Because death has occurred, the person's heart will stop beating shortly thereafter, and the body will be sent to the funeral home of the family's choice.

Death is always a difficult event for family members. Organ and tissue donation may be the only positive event that can come from the family's loss. This is why talking with patients in advance is crucial. It makes decisions at the time of death much easier on family members.

## Frequently Asked Questions

### Q: Who can be a donor?

*Anyone*, regardless of age, race, or gender can become an organ and tissue donor. Medical suitability is determined after the donor's death.

### Q: How do I become a donor?

*Tell your family.* Sharing your decision will make it easier for your relatives in the event of your death. Hospitals require consent from next-of-kin before organ and tissue donation can occur.

### Q: Which organs and tissues can be donated?

*Many, and one donor can benefit several seriously ill patients.* Organs and tissues that can be transplanted include the heart, lungs, liver, kidneys, pancreas, intestines, corneas, bone, bone marrow, and skin.

### Q: Will my decision to become a donor affect efforts taken to save my life?

*Absolutely not.* Donation is not considered until all possible efforts to save a patient's life have failed and death has been declared. The transplant team has no involvement in the patient's care before death. The team is notified only after death has occurred.

### Q: Is there any cost or payment for donation?

*No.* Donor families are never charged, and they will not receive any payment or compensation for the donation. Buying and selling organs is against the law.

### Q: If I needed a vital organ to live, would I be able to get one?

*Maybe.* Many people who need transplants of organs and tissue cannot get them because of a shortage of donations. Every month, more than 2,000 names are added to the national waiting list for organ transplants.

### Q: How are organ and tissue recipients selected?

*The National Transplant Act of 1984* established equal access to donated organs and tissues for all potential recipients. A national computer system matches donors and recipients on the basis of need and availability.

### Q: Do religious groups support organ and tissue donation?

*Yes.* All major religious groups allow organ and tissue donation. Religions such as Roman Catholicism and Judaism consider it not only consistent with, but also

an extension of, existing theologies of creation, justice, and love. If you have any questions, consult your religious advisor. (See also the resource sheet on religious views in this manual.)

**Q: Does donation affect funeral and burial arrangements?**

**No.** A person may make any burial arrangements desired. A traditional, open-casket funeral is possible.

**Q: Don't only the rich, famous, and well-connected get organs?**

**Absolutely not.** Anyone can become an organ or tissue recipient. Almost 20,000 people receive organ transplants each year. People with no connections at all get transplants every day.

**Q: How does organ allocation work?**

**Through a carefully managed matching process.**

When an organ becomes available, a computer search identifies potential candidates that match the donor's characteristics and prints out a list of patients ranked in priority order. Factors include blood type, body size, immune status, severity of illness, and length of time on the waiting list. Each donor generates a different list. Actually, all allocation issues boil down to not having enough organs. The solution is to persuade more people to become pledged donors so that no one has to make decisions about who lives and dies.

**Q: Are organ transplants successful?**

**Yes.** Studies show high survival rates among transplant procedures. At most US transplant centers, the success rate for kidney transplants is in the range of 90-95 per cent. Of the transplants performed in 1994, for example, 82 percent of heart transplant patients and 79 percent of liver transplant patients survived for at least a year. Some recipients have lived for 10, 20 years and more. These rates continue to improve as advances occur in technology and anti-rejection drug therapy.

**Q: What if the hospital errs in billing the donor family?**

**Don't fret.** Sometimes, because of hospital billing procedures, donor families receive bills that include some charges relating to the donation. Organ and tissue procurement agencies tell their donor families not to pay those bills until the agencies have had a chance to review them and pay their charges. Then the agencies have the hospitals re-bill the families for any charges that were not related to the donation.

**Q: Why does my family have the final say? What about me?**

**The family matters.** Although laws technically allow procurement agencies to recover organs and tissues without family consent, in practice this is not done. Hospitals and physicians by custom and policy defer to the family because they know the family lives on and must feel comfortable and at peace with what happens to their loved one. This respect for the families involved helps maintain public trust in the donation system.

**Q: Why carry a card around if my family makes the decision?**

**It saves time.** A donor card identifies you immediately, and emergency room personnel are instantly alerted of your wishes. In this way, donor cards save time, and time is crucial to a successful donation and transplant.

**Q: Can transplant recipients be donors?**

**Yes.** The medicine that recipients take to keep their bodies from rejecting the transplant will be the same medicine their recipients would take. The key factor is the viability of their organs at the time of their death, just as with other donors.

**Q: What about the kidney rumor?**

**It's just that - a rumor.** No ethical, licensed medical professional in the world would accept a kidney - or any other organ - that does not come complete with medical and social history and detailed identification through an OPO. This is simply not possible.

**Q: What if I die of advanced age or disease?**

**Donation of organ transplantation may not be considered.** However, organs and tissues that cannot be used for transplants because of advanced age or disease can often be used to help scientists find cures for serious illnesses. Call a nearby medical or dental school about making specific arrangements for donating your body to science.

**Q: Should I mention my donation decision in my will?**

**No.** The reading of the will usually occurs after the funeral arrangements are made or completed. However, preparing or amending a will can be an opportunity for informing your family about your donation decision because this is the time you will inform them about distributing your personal property among heirs.

**Q: Who pays for the transplant?**

The transplant recipient's health insurance policy (or Medicare or Medicaid) usually covers the cost of transplant.

**Q. Is there a national registry of pledged organ and tissue donors?**

**No.** However, some states maintain registries of individuals who indicate on their drivers' licenses that they wish to be donors.

**Q. Can I change my mind?**

**Yes.** Just tell your family and tear up your card.

## Religious Views on Organ and Tissue Donation

### Amish

The Amish consent to transplantation if they know it is for the health and welfare of the transplant recipient. In some cases, they might be reluctant to donate organs if a transplant outcome is known to be questionable.

### Buddhism

Buddhists believe organ donation is a matter that should be left to an individual's conscience. There is no written resolution on the issue. However, the Rev. Gyonny Musno, president and founder of The Buddhist Temple of Chicago and a practicing minister, has said: "We honor those people who donate their bodies and organs to the advancement of medical science and to saving lives."

### Catholicism

Catholics view organ donation as an act of charity, fraternal love, and self-sacrifice. Transplants are ethically and morally acceptable to the Vatican. Pope John Paul II has expressed concern about donors' psychological and physical integrity, but he has not taken any position against organ transplantation.

### The Church of Christ Scientist

Christian Scientists do not take a specific position on organ donation or transplants. They normally rely on spiritual rather than medical means for healing. The question of organ donation is left to the individual.

### Hinduism

Religious law does not prohibit Hindus from donating their organs, according to the Hindu Temple Society of North America. This act is an individual decision.

### Islam

In 1983 the Muslim Religious Council initially rejected organ donation by followers of Islam, but it has reversed its position, provided donors consent in writing prior to their death. The organs of Moslem donors must be transplanted immediately and should not be stored in organ banks.

### Jehovah's Witnesses

According to the Watch Tower Society, the legal corporation for the religion, Jehovah's Witnesses do not encourage organ donation but believe it is a matter best left to the individual's conscience. All organs and tissue, however, must be completely drained of blood before transplantation.

### Judaism

Judaism teaches that saving a human life takes precedence over maintaining the sanctity of the human body. A direct transplant is preferred. According to Moses Tendler, PhD, an orthodox rabbi, "If one is in the position to donate an organ to save another's life it's obligatory to do so, even if the donor never knows who the beneficiary will be."

### Mormons

The Church of Jesus Christ of Latter-day Saints considers the decision to donate organs a personal one. Jerry Cahill, director of public affairs for the Mormon Church, has said: "Mormons must individually weigh the advantages and disadvantages of transplantation and choose the one that will bring them peace and comfort. The Church does not interpose any objection to an individual decision in favor of organ and tissue donation."

### Protestantism

Protestants encourage and endorse organ donation. The Protestant faith respects an individual's conscience and a person's right to make decisions regarding his or her own body. Rev. James W. Rassbach of the Board of Communication Services, Missouri-Synod, has said: "We accept and believe that our Lord Jesus Christ came to give life and came to give it in abundance. Organ donations enable more abundant life, alleviate pain and suffering, and are an expression of love in the times of tragedy."

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*Information provided by the American Council on Transplantation, reprinted from Life Cycles, Hermann Hospital, Summer 1987.*

# Mississippi's Medical Giant: Felix Joel Underwood (1882-1959), The Man Who Saved a Million Lives

Lucius M. Lampton, M.D.  
Associate Editor

*"Underwood in my opinion is the ablest public health man we have in the United States. He is the essence of efficiency. He has outstanding executive abilities. He is a diplomat of the first order. He has good judgment. He is devoted to this work. His heart and soul are in it."*

— W. H. Anderson, M. D., editor of the Mississippi Doctor, to U. S. Senator Pat Harrison, February 24, 1936

*"Dr. Underwood was a king among physicians. He was Mr. Public Health."*

— Alton B. Cobb, M. D., MPH, past Executive Officer, Mississippi Board of Health

Every five years, the Board of Trustees of the Mississippi Department of Archives and History holds Hall of Fame elections. The trustees may only pick five Mississippians every five years. The five must be selected by unanimous vote of the trustees and must have been deceased at least five years. The Hall of Fame was established by the Department of Archives and History in 1902 and honors distinguished Mississippians with portraits on the walls of the Old Capitol Museum. At the last election, on December 6, 1996, Dr. Felix Joel Underwood was among five selected, which included *Delta Democrat Times* editor Hodding Carter, Choctaw chief Greenwood Leflore, *Northeast Mississippi Daily Journal* publisher George McLean, and U. S. Senator Hiram Revels (who was also the first African American to serve in the U. S. Congress). In selecting Underwood, the trustees cited his 34-year career as executive officer

of the State Board of Health. In those more than three decades, he organized the Board of Health into such an efficient disease-fighting agency that it became the model for states throughout the country. The trustees also cited his successful efforts at eradicating many common diseases plaguing the state and the building of immunization programs in the state.

Underwood is not the first Mississippi physician to be elected to the Mississippi Hall of Fame. The first was John Wesley Monette, M. D. (1803-1851) who was a practicing physician, historian, and public official in the old village of Washington just outside of Natchez. He authored historical, geological, and medical studies and is said to be the first to suggest quarantine for preventing the spread of yellow fever in 1837. He has a fine portrait hanging in the Old Capitol by famed artist Marie Hull.

The second physician named to the Hall of Fame is

David Lewis Phares, M. D. (1817-1892), a practicing physician from Woodville who was also a naturalist and educator. He served as president of the state medical association in 1884-5 and served on the first State Board of Health in 1877. He was a founding trustee of Mississippi A. and M. College (now Mississippi State) and was president and founder of Newton College in Wilkinson County. He was the first professor of biology at Mississippi A. and M. and wrote two books: *A Synopsis of Medical Flora in Mississippi*, 1878, and *The Farmer's Book on Grasses and Forage Plants for the South*, 1881. No portrait exists of Dr. Phares at the Hall of Fame.

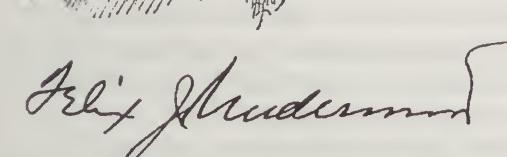
Underwood is good company for the other two physicians in the Hall of Fame, but in many ways he out-

shines both and truly is, as one of his successors Dr. Alton Cobb stated, the "king" among Mississippi physicians. He was born at Nettleton, Mississippi on November 21, 1882, the son of Marion Milton Underwood, a railroad worker, and Amanda Capitola Battle. Reared at Nettleton, a small railroad town on the Lee County/Monroe County border in northeast Mississippi, the young Underwood had to overcome financial hurdles to study medicine. But his destiny had been sealed at the age of ten, when he sat by his 32-year-old mother's bedside in the family farmhouse and watched her die of puerperal fever after childbirth. Her death and his feelings of helplessness in the face of death pushed him on the road to becoming a physician. To earn money for medical school, he worked as a clerk in a local drug store, wrote stories for the local newspaper *The Nettleton Advance*, and taught in the local schools. In 1904, he married Sarah Beatrice Tapscott, a co-worker at the newspaper, and the couple would become the parents of two children, Virginia Christine Underwood and Felix Joel Underwood, Jr. With his dedicated wife at his side, Underwood entered medical school at the University of Tennessee in Memphis, graduating in 1908. He then returned to his hometown where he practiced horse and buggy medicine for 12 years.

During his period of general practice in Monroe County, Underwood showed an interest in both public health and politics. He served for seven years as local health officer at Nettleton. For three years he served as director of the Monroe County board of health. He was early active in state gubernatorial campaigns and served from 1916-1920 as Chairman of the Monroe County Democratic Executive Committee.

He asserted his leadership in the Mississippi State Medical Association and was elected its president in 1919, after serving in various other leadership positions. He would later serve as president of the Southern Medical Association and represented Mississippi at most AMA meetings during his career. His "President's Address" at the May 1920 MSMA meeting appealed to his physician peers to "stand as immovable as Gibraltar for the highest and the best." This determined pursuit of excellence would serve him well as he undertook the great duty of his life, public health service, doing what he would call "the great and necessary work of protecting life and health in Mississippi."

In January 1921, his adventure in full-time public health work began: he was appointed as director of the Bureau of Child Hygiene and Welfare. The job would take him forever out of the world of private practice in Monroe County and place him on the stage of public health in the state capital, Jackson. Why did he leave



A pen and ink sketch of Dr. Felix J. Underwood in 1929. The artist was Harry Palmer. Below the print is his signature.

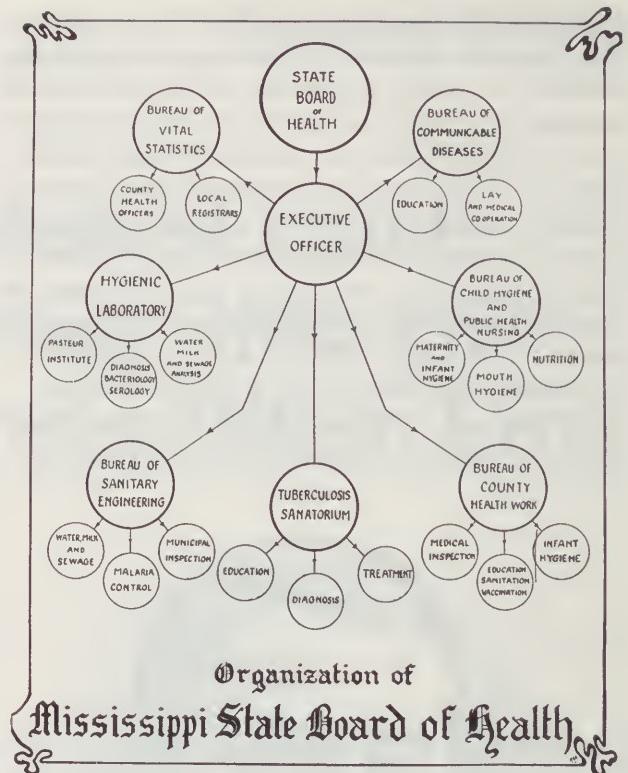
private practice for public health? He told his wife at the time, "As a private doctor, I can never care for more than two or three thousand people. As a public health officer, I can care for millions." (*American Magazine*, September 1954, 119) During his career as a state public health official, he would often refer to his "2,225,000 patients." Upon arriving in Jackson, he purchased for his family a modest frame residence at 1058 North Congress Street, and there he would reside the rest of his life.

Underwood's new job placed him in the Board of Health offices at the Old Capitol, working in close association with the first full time executive officer of the State Board of Health, Dr. Waller Smith Leathers (1872-1946), a Virginia born, Johns Hopkins and Harvard educated academic physician who served as Dean of the two year medical school at Ole Miss from 1906-1924. He had been selected in 1910 to serve as director of the State Board of Health. Leathers was a gifted and intelligent public health advocate whose example would help mold the younger Underwood. In 1924, Leathers left Mississippi to join the faculty at Vanderbilt University Medical School, where he would later serve as dean.

Underwood had distinguished himself in his work under Leathers and on July 1, 1924 was designated his successor. That same year, Underwood had the added benefit of a state law freeing the State Board of Health from political interference. When he assumed leadership of the Board of Health, Mississippi ranked at the bottom of most health statistics and had few hospitals and no four-year medical school. Sanitation in the age of the privy was very poor and a major contributor to health problems. Poverty and ignorance abounded. Underwood saw much to do.

Among his early accomplishments were: shellfish sanitation work, marriage registration, the organization of a training station for public health workers, initiating postgraduate medical education, inaugurating industrial hygiene programs, mid-wife registration, and adopting milk ordinances. He was not afraid to confront subjects often taboo in conservative Mississippi. Asking for "social courage" on the part of physicians, he criticized the "national hush-hush policy concerning syphilis" and encouraged "giving of adequate sex information to younger age groups. The safeguarding of this one growth process can be considered preventive medicine of a high order." (*Mississippi Doctor*, September, 1937, 37-40) In 1927 he called the nicotine in tobacco "a deadly poison." He was an early proponent for a "planned parenthood program," calling it "vital" for public health.

In an era when race dominated all aspects of Mississippi life, Underwood directed much of his energies at



The administrative organization of the Mississippi State Board of Health in 1928.

black problems. He included blacks among those receiving medical education scholarships. He also publicly directed attention to black morbidity.

"With Negroes comprising more than fifty percent of our population, our infant and maternal death rate will continue unreasonably high unless vigorous measures are taken to improve the health of Negro mothers and babies," he said in 1937. (*ibid.*)

He fought indifference to the poor plight of many blacks and stated, "There's one of the best preventive medicines: decent housing, better pay. T. B. and all kinds of diseases have always been highest among Negroes. Why? Not because the Negro has some constitutional defect. But because of crowding and malnutrition." He perceived the connection between social stressors and public health, and clearly saw broad influences, from income to class to education to race, on the public health. "It is much easier to prevent than to cure an illness," he stressed. (*Religion and Health*, 1)

In 1932 and 1936, his name was frequently tossed about as the "next" Surgeon General of the U. S. Public Health Services. Franklin D. Roosevelt never appointed

him to this position, but he did serve on the national level as public health advisor to the President's Social Security Committee. Underwood was an advisor to U. S. Senator Pat Harrison, who headed the powerful Finance Committee, when social security legislation was shaped. Underwood frequently spoke in Washington at Congressional committee hearings. He used his national connections when state funding for health dropped during the depression, utilizing federal programs that were part of Roosevelt's New Deal to initiate a free immunization program for Mississippi's poor.

After World War II, Underwood stepped up his battle for better hospitals in the state. In 1946, the Legislature set up a Commission on Hospital Care, and of course, Underwood was a force on the Commission. With his leadership, a progressive state hospital plan was formulated. The first contract in the nation for building a hospital under the Hill-Burton Act was awarded at Booneville, Mississippi on June 9, 1948.

In that decade from 1945-1955, he also battled strongly to relieve state physician deficiencies. He felt a shortage of doctors was as dangerous a threat for the state as a shortage of hospitals. Underwood wanted more doctors, and he wanted to create them here in the state. As vice-chairman of the State Medical Education Board, he persuaded the 1946 Legislature to establish the medical education scholarship loan program, which provided state loans for medical students willing to spend two years in rural general practice. Although subsidizing physician education today is common, it was unique in the 1940s, and other rural states patterned similar programs after Underwood's.

Even more important in solving the post-war physician shortage was the creation of a four-year medical school in Mississippi. Underwood's importance in the long legislative process of creating the University Medical Center in Jackson would be difficult to overstress. He plotted strategy and lobbied legislators relentlessly until the center was established in 1950.

Louise Williams, longtime Librarian at the State Board of Health, wrote of Underwood's devotion to the establishment of a four year medical school in Jackson:

"The Exchange Club was only one of the civic groups promoting the 4-year medical school. Dr. Underwood gave Hayden Campbell [state senator pushing for the 4-year school] space and facilities at the Old Capitol to undertake this program for the school. Dr. U. also used his influence and prestige at every critical point to ensure its realization. Only those who worked for him are aware of how much he

did. I would like to hope that someday someone would establish an award or lectureship bearing his name.

"He helped many young physicians to be to find their way to medical school through Commonwealth Fund and other scholarship funds and he helped to encourage professional advancement through medical extension courses and seminars. Moreover, he developed or encouraged the development of the best potential in his own personnel, giving the nation one of its finest public health programs of any state. I would never have had the courage to step into such rewarding work (medical librarianship) as I do except for his confidence in me and his encouragement." (Louise Williams to Maurine Twiss, May 6, 1970; a lectureship was established at UMC in Underwood's name in Preventive Medicine and Public Health)

For his health campaigns, he tirelessly promoted his causes in the state. He spoke to rotary clubs, at health center and hospital dedications. He spoke on radio broadcasts, lectured widely, badgered authorities, and distributed leaflets. He worked as president of various state health societies, including the Mississippi Division of the Cancer Society, the heart association, and the March of Dimes.

One of these battles was an unsuccessful one to make mandatory fluoridation of Jackson's water supply. When Underwood appeared before the Jackson city council, he yanked his false teeth out of his mouth to stress his point. "This is what I'm trying to get away from," he told the council. "It's too late for me, but I want fluoridation to help the youngsters."

As president of the State Board of Examiners for Nurses since 1931, he signed every nurse's license from 1931- 1958, and as the executive officer of the State Board of Health since 1924, he signed the license for every physician to practice medicine in the state from 1924 - 1958. He authored two books with Dr. R. N. Whitfield on the history of public health in Mississippi: *Public Health and Medical Licensure in the State of Mississippi 1798-1937*, (1938) and *Public Health and Medical Licensure in the State of Mississippi 1938-1947, Volume Two* (1950). He worked closely with Dr. Henry Boswell in developing and supporting the Mississippi State Tuberculosis Sanatorium at Magec, which the State Board of Health supervised.

As his prestige grew, he was often encouraged to run for political office. His name was seriously discussed in the newspapers as a leading contender in the race for

lieutenant governor in 1938. (*Times Picayune*, September 18, 1938) He also considered several times running for governor of the state. In the end, he stayed the course at the Board of Health, content to remain the major player in any and all health decisions made at the Capitol.

In 1953, after 29 years as the state's top health officer, Underwood received the coveted "Albert D. Lasker Award" of the American Public Health Association, the medical award equivalent of the "Oscar." This award resides today in the administrative offices of the health department. On the winged gold statuette is written: "For demonstrating how a long-sustained, sound, and expanding pattern of public health benefits a people."

Dr. Frank Boudreau, chairman of the Lasker Award Committee, stated at the time:

"Dr. Underwood has transformed his state in three decades into a national pacesetter in promoting public health. Working with the medical profession, health experts, political leaders, private foundations, and private citizens, he has in one lifetime extended the range of public health far beyond the mere curbing of epidemics."

"His stream of accomplishments includes county health units; child guidance clinics; mental health and service programs for working families; a new state medical school; a unique program for rural medical education; and the conquest of malaria and venereal diseases as part of relentless clean-up campaigns which have profoundly influenced the South and the nation."

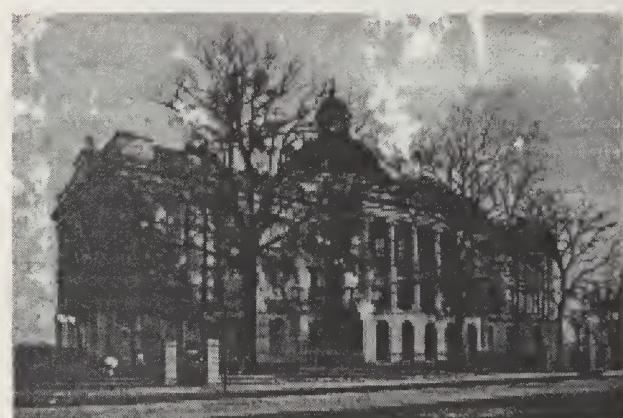
During Underwood's career, deaths from malaria in the state were reduced from 1000 annually to less than one every ten years. Venereal disease dropped 93%. As soon as diphtheria vaccine was available, he led the campaign to immunize all the children in the state. He was quick to distribute the Salk polio vaccine in the state as soon as it was available.

One of his most noticeable accomplishments was in maternal mortality. Maternal deaths dropped from 7.4 per 1000 live births to 1.8 during his period of service. "This has been the most gratifying achievement of my service," he said.

One of the more telling signs of what Underwood accomplished is embodied in a story about him. A Jackson friend saw him roaming about an old cemetery with a yardstick in hand. "The average length of a grave has gradually increased," he noted. He further commented that this was due to dropping mortality rates in infants and

children with improvements in public health.

The Department of Health for Underwood's entire career was located in the then dilapidated Old Capitol building. The department first located in the building in 1917, and eventually, during Underwood's tenure, took over all of the corridors in the building by 1950 and even expanded into several outbuildings behind it. The first floor offices were occupied by vital statistics and administration. On the second floor were the divisions of public health nursing, health education, communicable diseases, venereal diseases, mental health, school health, maternal and child care. On the third floor were field services, county health, sanitary engineering, and environmental health. To the rear of the north wing was a two-story building that housed the laboratory. Another out-building, straddling the bluff, housed a print shop. There was a small barn below the bluff that housed sheep and rabbits, which were used in the laboratory.



The Old Capitol Building in early 1900s—This structure housed the State Board of Health throughout Dr. Underwood's tenure as chief officer. He died there in the offices of the board in 1959. A Hall of Fame portrait would be placed in the building when complete. [Photo from an old postcard mailed in 1908 by a woman en route from Hazlehurst to Vicksburg via train, postage cancellations in Jackson and Canton. —Ed.]

Dr. Underwood's office was in the northeast corner of the first floor, and across the hall was his large medical library, run by longtime librarian Louise Williams. (This wonderful library is now housed at the Rowland Library at UMC.) The old building had its problems. It lacked air conditioning, the heating was inadequate, and cracked plaster was falling as the paint was peeling. Efforts in the Legislature to erect a new health building near the new medical school on North State Street began in the early 1950s. During J. P. Coleman's governorship, the project became a reality. A four-acre site was selected at 2423 North State Street and building began. However,

Underwood would never work there. He retired on June 30, 1958, only after forced to do so by a public employees retirement law.

His longtime executive secretary Cleta Brinson remembered him:

"Although he was a state, a national, and even an international public health leader, he was never too busy to listen to problems of his fellow workers and to help resolve them. He had the unusual gift of being able to overshadow one's frustrations and restore one's faith in his ability to overcome whatever his difficulty. A fellow employee came by my desk one day furious with a co-worker and told me he was going to see Dr. Underwood about the matter. I was tense during this time thinking that 'feathers were really flying.' Finally the door opened. The person who had been so mad only a few minutes earlier stopped by my desk and told me we were going to have a new State Board of Health Building and that he became so enthusiastic over Doctor Underwood's description of the new building that he failed to tell him of his grievance—and this was long before the Building Commission and Legislature had authorized a new State Board of Health Building." (Comments, MPHA, 22 October 1969)

The construction of a new State Board of Health Building was a fitting climax to Underwood's exceptional career. The state Legislature named the building in his honor, overlooking the long established tradition against naming a public building after a living person. No other public structure in Mississippi had ever been named for a living person. Even though he retired in June of 1958, he maintained an office at the State Board of Health in the Old Capitol, working as a consultant to the department without pay. On January 9, 1959, after a full day of activities, without warning and while standing beside the desk of his longtime secretary Cleta Brinson, this public health statesman collapsed. He could not be revived and died at the Old Capitol, in the very offices in which he had so long worked. The state and nation mourned him and he was buried at Cedar Lawn Cemetery in Jackson. Four months later, on April 17, the "Felix J. Underwood State Board of Health Building" was officially dedicated.

One of the best editorials written at his death was that by his friend Oliver Emmerich, Editor of the *Jackson State Times*. Emmerich noted:

"When Dr. Underwood became executive head of Mississippi's State Board of Health, thousands of



Felix Joel Underwood, M. D., in the late 1940s, at the zenith of his great career.

people moped about the state like zombies, listless and half alive, victims of malaria. Our infant mortality rate was tragically high. Death from typhoid was as routine as the seasons. Little children were strangled by diphtheria. Tuberculosis was the major killer. Our people were backward and poor as the result of diseases and distress.

"It is no wonder that Dr. Underwood was referred to as the man who had saved a million lives. The life expectancy of our people—you and I—was lengthened. And our standard of health lifted as a result of his dedication and devotion...Dr. Underwood knew the meaning of faith, the essence of kindness, the magnificence of loyalty and with it all he was gentle. Indeed, this is the substance of greatness. He loved his many friends—and we loved him.

"No epitaph need be inscribed on a tombstone for him. It is already recorded in the communicable diseases statistics of a sick people made well. He was our unselfish benefactor." (*State Times*, January 10, 1959)

At the May 1999 session of the MSMA, a resolution was introduced, overwhelmingly supported, and then adopted which stated that the MSMA join in the efforts to commission a suitable portrait of Dr. Underwood to be placed in the Mississippi Hall of Fame. Reference Committee B concluded upon review of the resolution: "Your reference committee was reminded of the extraordinary and exemplary 30 year career of Dr. Felix Underwood as Mississippi's top public health official and as a leader in the association. He is truly one of our profession's most outstanding representatives and the reference committee believes it is incumbent upon us to join with our colleagues in the Public Health Association to commission a portrait of Dr. Underwood for the Hall of Fame."

Among the artists being considered for the project are Eric McDonald, Ann Dunbar, and others. The amount of money needed for the portrait (to be painted from a photograph) is significant, \$6,000 to \$20,000, depending on the approved list of artists at the Mississippi Archives.

*The Board of Trustees of the MSMA is sponsoring  
the fund-raising in collaboration with the Mississippi Public Health Association. Anyone wishing  
to support this should contact board members as  
well as making a tax deductible gift to the Mississippi  
Department of Archives and History, with  
the notation on the "for" line for the "Dr. Felix  
Underwood Hall of Fame Portrait Fund." Send to  
Ms. Donna Dye, Director, Old Capitol Museum,  
P. O. Box 571, Jackson, Mississippi 39205-0571.*

Mississippi physicians need to honor the legacy of Underwood by supporting this project. He is our Osler, our Gorgas, and our Matas. His portrait when completed will hang in the Old Capitol, appropriate in that within those historic walls Dr. Underwood directed health care in the state for more than 30 years and even died. He encouraged physicians with his high ideals and standards of excellence. He once said,

"Aiming high is most honorable, but stopping short of the summit is disgrace. Some people, when they

begin to see the rays of light over the crest of the hill, get dazzled and sit down on the mossy bank to breathe and exult. By the time they have rested and resumed the journey, they find the point of vantage on the top already occupied by the plodder. Keep at it while you are under way. To stop and start again is a waste of energy. There will be time to stop when the journey is ended, the work done, and the summit reached." (Religion and Health, 3)

For 34 years as executive officer and secretary of the State Board of Health, Dr. Underwood never rested on the mossy bank, but kept relentlessly plodding on for Mississippi. He left an indelible imprint in the history of his beloved home state as the guiding genius of medical progress. He was a tireless warrior in man's unending struggle with disease and death. Underwood is the Mississippi physician of the twentieth century. As we approach this century's end, more than 40 years after his death, he remains the most outstanding physician Mississippi has ever produced.

*If you would like to know more about this project please contact Dr. Alton Cobb, telephone number (601)957-1575, or Dr. Alfio Rausa, (601)453-4563 who are spearheading this fundraiser on behalf of the Mississippi Public Health Association. — Ed.*

(Please complete and mail.)

Enclosed is my tax-deductible contribution of \$ \_\_\_\_\_ for the "Dr. Felix Underwood Hall of Fame Portrait Fund."

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Make check payable to the: Mississippi Department of Archives and History.

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## Annual Health Plan Process Begins

The Mississippi State Department of Health develops a State Health Plan each year under the authority of Section 41-7-173(s) and Section 41-7-185(g), Mississippi Code 1972 Annotated, as amended. The State Health Plan has three purposes: (1) to identify priority health needs in Mississippi; (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process through final adoption of the revised Plan.

The process begins each fall with a public forum generally held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the Plan or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and files the proposal with the Secretary of State. This action

initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act.

The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "final adoption" of the revised Plan. The Department files the Plan as adopted with the Secretary of State.

Staff also obtains up to date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the Plan. Staff compiles this information and produces a final Plan. Following approval by the Governor, the revised Plan becomes effective July 1 of each year.

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## Actions Speak Louder Than Words

**W. Briggs Hopson, Jr., M.D.  
The President's Page**

**H**ow many of you reading this have heard this old saying? Yet, how few of us really take it to heart. How many of us complain about something but fail to offer a suggestion on how to correct it? How often do we complain about health care problems? I don't know about you but almost weekly I hear physicians complaining about managed care, malpractice premiums, scope of practice, infringement upon practice, loss of revenue, government control, and the list goes on and on. I hear the complaints but I rarely ever hear many solutions.

As I thought about the complaints, I realized that there are many solutions but almost all take legislative action. HMO's can be curtailed by legislative action. Scope of practice can be protected by legislative action. Malpractice premiums can be reduced by Tort Reform. Loss of revenue can be improved with legislative action. Governmental control can be reduced by legislative action. Patients can be given a meaningful bill of rights. In fact, everything we want to happen is basically controlled by our legislators.

How do we control our destiny? Ask yourself. We control it by controlling our elected officials. It sounds simple. Maybe it is so simple that we never think about it. Think about this. This is election year. All members of the House and Senate are up for election, as well as the governor, lieutenant governor, attorney general, state auditor, and others.

I recently saw partisan politics at its best. I saw a Senate so worried about party lines, personalities, and insurance companies that they forgot the people who are their friends and neighbors. They failed to realize that patients come before party, patients come before pay, and patients come before premiums. They failed to realize that the patient/physician relationship is the cornerstone of medical practice in this country.

If we want to get changes made, we must elect people we can talk to, people who are pro medicine, and people who care about patients and health issues. How do we do this? We do it by action. First, we support AMPAC and MMPAC. Then we personally talk to the candidates. Finally, we support them, not just monetarily but really working for them by talking to our patients, families, and friends. We encourage people to vote, even take them to the polls if necessary. Then and only then can we really ask for the politicians' help. Yes, as election time nears, action does speak louder than words.

A handwritten signature in black ink, appearing to read "Briggs".

## OPTIONS

You never know when you're being "sized up". Beth and I were driving back from Chicago after participating in Ed Hill's wildly successful AMA Trustee campaign a couple of summers ago when we became acutely aware of the need to refuel both our vehicle and our stomachs.

Necessity directed us off the interstate to that precariously named town, New Madrid, Missouri. Surprised at the inability to find either a "brand name" gas station or fast-food outlet, we pulled into a mom-and-pop operation to regroup-- and at least for a bathroom break!

Once inside we discovered an old-fashioned market offering no-frills sandwiches from a variety of "by-the-slice" meats-- a handy to-go lunch. After deciding on ham, I was asked by the lady behind the counter, "White or brown bread?" When I indicated brown, she winked at her husband, "I told you so!"

Life's most memorable options are usually more complicated than sandwich bread selections. And through a recent personal turn of events, it has become even more apparent that they are not always limitless.

The ominous mammogram report of the lump which seemed to have sprung fully grown into my wife's breast demanded biopsy. In a dramatic reversal of roles from physician to patient, I suddenly experienced the helpless frustration of a restricted physician referral pool, thanks to the marvels of managed care. Fortunately, the bedside manner of our selection proved to be as reassuring as the reputation of his competence.

Infiltrating duct cell carcinoma... malignant ... cancer ... the finality of the pathology report evoked an emptiness more profound than that of receiving a malpractice suit summons and called for life-changing decisions: Lumpectomy and radiation versus mastectomy and chemotherapy ... prosthesis versus reconstructive surgery. An abiding faith, the powerful prayers of both friends and strangers, and an unselfish love for one another provided stability as we dealt with this unwelcome, rude visitor.

As we headed down the stairs for Jackson and surgery, the thirty-one year old wedding portrait of the radiant bride and the lovestruck groom caught my eye. The option of where to hang the photograph commemorating our 50th anniversary will hopefully someday be ours.

— **D. Stanley Hartness, M.D.**

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

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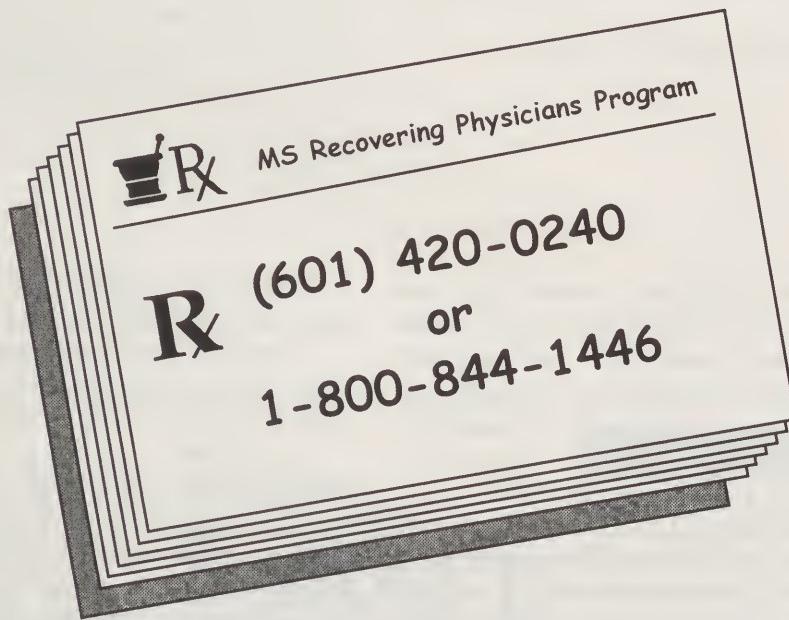
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## Information and Quality Health Care

Dr. Ralph Dunn of Madison has assumed the duties of medical director for the Payment Error Prevention Program (PEPP), which began Aug. 1 with the Sixth Scope of Work. PEPP was designed by the Health Care Financing Administration to address the payment error rate for PPS inpatient hospital services. The goal is to reduce the rate by ten percent by the year 2002.

A native of Hattiesburg, Dr. Dunn studied pre-med at Tulane University and graduated first in his class at Tulane Medical School. Internship included general rotation at UMC. He was in general practice in Morton for four years, then completed his residency in anesthesia at UMC. He practiced anesthesia at Jackson Anesthesia Associates from 1961 through 1998 and served as interim chairman for Risk Management Medical Assurance for 15 years.

### Tobacco Quitline

I.Q.H. has been awarded a grant from the Partnership for a Healthy Mississippi to conduct, staff and maintain a tobacco cessation quitline. The toll-free number, which was scheduled to be operational Labor Day, will allow persons interested in stopping tobacco use to call in and receive support counseling over the phone as well as referrals to treatment programs and support groups.

Other grant participants are the Mississippi Academy of Family Physicians, which has the responsibility for the clearing house of tobacco cessation information, and the University of Mississippi Medical Center, Adolescent Child Tobacco Cessation Treatment Center.

The grant is a pilot project to determine the interest and need of such services in the state.

Pamela Graef Luckett, MCC, LPC, program specialist, will provide supervision and training for the counselors at I.Q.H. The quitline number is 1-800-844-0500.

### Maggie Awards for I.Q.H.

I.Q.H. and Broderick/Bates Advertising of Jackson are among the winners in the 12th Annual Maggie awards sponsored by the Mississippi Hospital Association Society for Health Care Marketing & Public Relations.

*The awards, named Maggie for the state flower, the magnolia, honor excellence in the field of health care marketing and public relations in the state. Over 350 entries from more than 30 hospitals and health systems were judged.*

The highest honor is the Maggie, followed by certificates of merit.

The categories for which I.Q.H. and Broderick/Bates were recognized include:

*Maggie awards for: brochure, Information and Quality Solutions for Healthcare; poster produced externally, name change poster; logo produced externally; magazine advertising, I.Q.H. Four Color Series; Best Print Media entry, pocket folder overview brochure; certificate of merit for a publication/external audience, Smart Solutions.*

## CVO Offered at I.Q.H.

The Credentials Verification Organization formed at I.Q.H. offers credentials verification in a timely, efficient and cost-effective operation. The credentials verification service includes customized reporting and staff to answer physician/provider questions and concerns. A nationally recognized, comprehensive practitioner verification software is supported by I.Q.H.'s full-time, in-house information systems and analytic/statistical departments.

Credentialing has been primarily a function of hospital medical staffs, but in recent years third party payers, regulatory and accrediting agencies required hospitals to perform organized and well-documented credentialing processes. I.Q.H. policies and procedures assist in ensuring compliance with external review agencies and accrediting bodies while minimizing legal risk.

I.Q.H. staff can assist in the verification process by conducting primary source verification, gathering letters of reference and substantiating clinical training and experience. Verified information is returned to the facility for completion of the credentialing process and final decision by the governing board. Delegating the verification portion of the process allows for more efficient use of time and resources by medical staff office personnel.

In most cases, practitioners have to complete only one application for additional affiliations. Information is also current at all times because of the systematic methods utilized to update the files.

*For more information, contact Dr. Denise Autonberry or Susan McMillan, RRA, at 601-957-1575.*

— James S. McIlwain, M.D., President

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## Personals

**Bryan M. Clay, M.D.** and **Kyle F. Gordon, M.D.** have become associated with the Ear, Nose & Throat Surgical Group, P.A. in Jackson.

**Ken Harvey, M.D.**, a board-certified internal medicine physician with IMA-Tupelo, was recently appointed medical director of North Mississippi Medical Clinics. North Mississippi Medical Clinics is an affiliate of North Mississippi Health Services in Tupelo. As medical director, Dr. Harvey is responsible for the management of clinical quality, peer review, credentialing and executive committee matters.

**D. Russell Young, M.D.** has joined Jackson Heart Clinic, P.A. in Jackson in the practice of cardiovascular diseases.

**William E. Henderson, M.D.** has recently joined Oxford Clinic for Women. A native of Oxford, he earned a medical degree from the University of Mississippi School of Medicine in Jackson where he also completed a residency in obstetrics and gynecology.

**Tom Woolridge, M.D.**, a board-certified nephrologist with Nephrology and Hypertension Associates, was recently elected Chairman of the Medical Review Board of Network 8. The Medical Review Board is the governing body for dialysis units in Network 8, which includes Mississippi, Alabama and Tennessee. As chairman, Dr. Woolridge is responsible for supervising the quality of dialysis medical care in these states.

**Thomas L. Lewellen, Jr., D.O.** has joined Gamble Brothers and Archer Clinic, P.A. for the practice of obstetrics and cardiology in Greenville.

**Randy Roth, M.D.** was the host of "Hospitalists: Hospital Care Specialists" at the Pascagoula Public Library. The hour-long program introduced what a hospitalist is and gave an overview of what they do. Hospitalists take on the responsibility for patient care during a patient's stay at the hospital. They are physicians who specialize in the care of hospitalized patients. They typically have limited or no outpatient responsibilities and do not have a busy office schedule to deal with so the hospital becomes their office. Dr. Roth foresees an innovative and progressive program that benefits all involved, including the hospital, the doctors and most importantly, the patient. The goal is to improve patient satisfaction and the quality of care. Hospitalists inform patients' personal physicians of all major decisions made in the hospital and send them complete discharge summaries. Dr. Roth is director at Inpatient Physician Services in Pascagoula, specializing in internal medicine. His residency and internship was completed at Baylor University Medical Center in Dallas.

**Scott E. Harrison, M.D.** recently completed a pediatric otolaryngology-rhinology and sinus disease fellowship at the University of Virginia and has joined The Jackson Ear, Nose and Throat Clinic in Jackson.

**Clifton W. Story, M.D.** has recently joined River Oaks Health System's East River Clinic as a family medicine practitioner. The East River Clinic is part of The Preferred Medical Network. In 1991, Dr. Story received a bachelor of science degree from Mississippi State University in Starkville, where he majored in general science and graduated cum laude on both the Dean's and President's Lists. He received his medical degree from the University of Mississippi School of Medicine in Jackson in 1995. He completed his residency in Family Practice at the University of Mississippi School of Medicine. Dr. Story's medical experience includes serving as a M4 Receptor with the Southern Baptist Convention's Foreign Mission Board in Bangkok, Thailand and as a MECO student in the Emergency Room at Rankin Medical Center.

**John P. Fullenwider, M.D.** has been named a Paul Harris Fellow by the Rotary Club of Oxford. Dr. Fullenwider, owner and medical director of JPB Pathology, is on staff at Baptist Memorial Hospital-North Mississippi. Paul Harris Fellows are Rotarians who make significant monetary contributions to The Rotary Foundation, which funds charitable and educational programs internationally to foster world peace.

**Jennifer O. Hicks, M.D.** has joined Truly's Family Medical Clinic in Canton in the practice of Obstetrics and Gynecology.

# Placement / Classified Service

## SLEEP MEDICINE FELLOWSHIP

**Sleep Medicine Fellowship**--A one-year, accredited sleep-medicine fellowship is available to begin in September, 1999, and is open to a fully-trained neurologist, psychiatrist, pulmonologist or pediatrician. The University of Mississippi Medical Center Sleep Disorders Center is a nationally accredited facility. Within this excellent university-hospital, academic, clinical and research setting, the patient flow is active and varied. The program is full-time for a 10- or 12-month period. The fellowship salary is \$35,000 plus malpractice and health insurance. This program satisfies eligibility for the American Board of Sleep Medicine examination. To apply, please contact: Howard P. Roffwarg, M.D., ABSM or Sinan Baran, M.D., ABSM, Director, Sleep Disorders Center, Department of Psychiatry and Human Behavior, University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216-4505, Telephone (601) 984-4820, Fax (601) 994-4828. The University of Mississippi Medical Center is an EOE, M/F/D/V.

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# Mississippi Institutions and Organizations Accredited as Providers of Intrastate Continuing Medical Education

The following medical institutions or organizations have been accredited as providers of CME by the MSMA's Council on Medical Education. Accreditation is awarded in accordance with the ACCME's/MSMA's "Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education". Information concerning CME programs and activities for physicians offered by these accredited sources may be obtained by writing or calling the Director or Coordinator of CME at the individual institution or organization.

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Columbus, MS 39701

Baptist Memorial Hospital-North MS  
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Oxford, MS 38655

Biloxi Regional Medical Center  
150 Reynoir St.  
Biloxi, MS 39530

Council on Scientific Assembly  
MS State Medical Association  
408 West Parkway Place  
Ridgeland, MS 39158

Delta Regional Medical Center  
1400 E. Union St.  
Greenville, MS 38704

Forrest General Hospital  
Mamie Street & Highway 49 South  
Hattiesburg, MS 39404

Greenwood Leflore Hospital  
1401 River Rd.  
Greenwood, MS 38930

Grenada Lake Medical Center  
960 Avent Dr.  
Grenada, MS 38901

Jeff Anderson Regional Medical Center  
2124 14th St.  
Meridian, MS 39301

King's Daughters Hospital  
300 S. Washington St.  
Greenville, MS 38702

Medical Assurance Company of MS  
735 Riverside Drive Suite 301  
Jackson, MS 39202

Memorial Hospital at Gulfport  
4500 13th St.  
Gulfport, MS 39502

Central Mississippi Medical Center  
(formerly Methodist Healthcare)  
1850 Chadwick Dr.  
Jackson, MS 39204

Mississippi Baptist Medical Center  
1225 N. State St.  
Jackson, MS 39202

MS State Department of Health/  
MS Association of Public Health Physicians  
P. O. Box 1700  
Jackson, MS 39215

Natchez Regional Medical Center  
54 Sergeant S. Prentiss Dr.  
Natchez, MS 39215

North Mississippi Medical Center  
830 S. Gloster St.  
Tupelo, MS 38801

Northwest MS Regional Medical Center  
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Clarksdale, MS 38614

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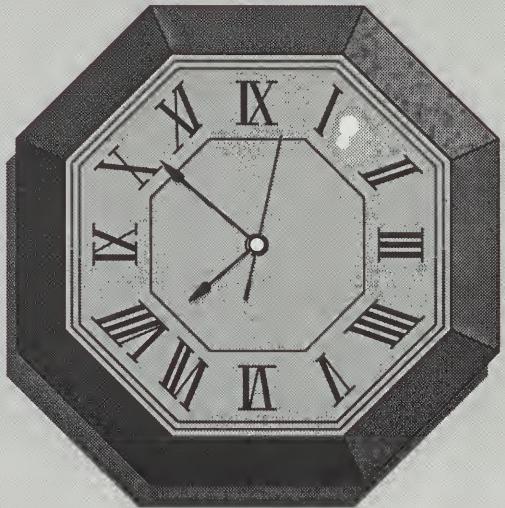
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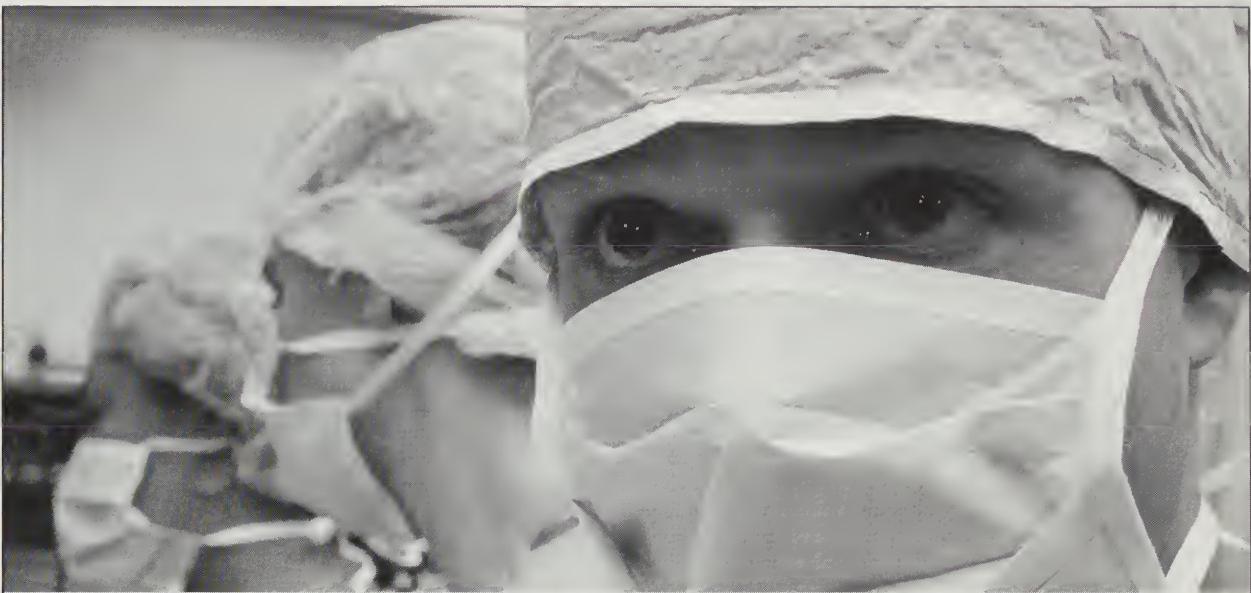
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# Lyme Disease

Thomas P. Forks, D.O., Ph.D.

In 1975, in the obscure, previously little known town of Lyme Connecticut, a suburban mother noted that an unusually high number of neighborhood children had been diagnosed with juvenile rheumatoid arthritis. She adeptly notified the state health department that 12 of the neighborhood children had developed unusual arthritic complaints. Subsequent research by Allen Steere<sup>1</sup> and colleagues identified a new disease, named for the town of Lyme, Connecticut where it was first identified. Lyme disease is characterized by an enlarging, erythematous rash referred to as erythema chronicum migrans (ECM) or erythema migrans (EM). The original research study included 29 children and 12 adults. As is typical in cases of Lyme disease, only one of these 51 patients recalled being bitten by a tick. Cases of Lyme disease have increased exponentially in numbers over the last few years and it has now become the fastest growing and the most common of the ten currently recognized North American arthropod borne infections.

### Clinical Manifestations

Lyme disease may be manifested by integumentary, arthritic, cardiovascular and neurologic symptoms. The skin rash, erythema migrans (EM) is the hallmark of early disease but may not be present in up to 30 % of patients. EM is typically flat or raised very faintly, mildly red, warm, and averages up to 15 cm in diameter. Although somewhat variable, EM is usually nontender and nonpruritic. The rash of many patients may have a central

clearing surrounded by a brighter, erythematous ring (target lesion). Multiple other small secondary skin lesions may also be present. Early manifestations of Lyme disease may also include a low-grade fever, muscle and joint aches, a generalized swelling of lymph nodes, neck stiffness, headache and fatigue. Late disease is characterized by cardiac, neurologic and arthritic manifestations.

Cardiac manifestations may occur in up to 8 % of untreated patients and typically present several weeks after the tick bite. These abnormalities most commonly involve myocarditis and a prolongation of the PR interval. Various degrees of heart block including complete heart block can occur. Cardiomegaly and left ventricular dysfunction may also be seen.

Approximately 15% of untreated patients will develop neurologic abnormalities. These neurologic abnormalities are generally manifested a few months after the tick bite and may include lymphocytic meningitis, encephalitis, radiculoneuritis and cranial neuropathies. Bell's palsy, the inflammation of the seventh cranial nerve is the most commonly noted cranial neuritis. Lyme meningitis has been shown to be as common as viral meningitis in Lyme disease endemic localities.<sup>2</sup> Peripheral nerve involvement occasionally occurs. Phrenic nerve inflammation and subsequent diaphragmatic paralysis as a consequence of Lyme disease has been described in the literature.<sup>3</sup> These authors described the resolution of the patient's facial and dia-

phragmatic nerve palsies within 8 weeks after standard treatment with doxycycline. Late neurological manifestations of Lyme disease may include ataxia, spastic paresis and a chronic encephalopathy. Late sequelae very similar to multiple sclerosis and neurosyphilis have been reported in the literature.<sup>4</sup> Psychiatric disorders may also occur as a result of infection with *Borrelia*. Hess et al.<sup>5</sup> reported the development of a schizophreniform disorder in a 42-year-old patient with Lyme disease. The patient's psychiatric disorder cleared with successful antibiotic treatment of her Lyme disease. Other researchers have demonstrated a significant decline in the cognitive ability and rapidity of thought processes in Lyme disease patients.<sup>6</sup> Ophthalmologic abnormalities may include retinitis, retinal hemorrhage, iritis, conjunctivitis and choroiditis.

Arthritic abnormalities, most frequently involving the knees occur in up to 60% of untreated patients. Involvement of the shoulders, spine, hips, elbows, ankles and temporomandibular joint is not uncommon. Lyme arthritis occasionally occurs as soon as a few weeks after the tick bite but may present several years later. Other skeletal abnormalities include the development of osteomyelitis and panniculitis. Some patients develop fibromyalgia as a consequence of their Lyme disease.<sup>7</sup> Fibromyalgia is resistant to antibiotic treatment.

### Natural History

The causative agent of Lyme disease (*Borrelia burgdorferi*) was finally cultured and identified by Burgdorfer and Barbour at the Rocky Mountain Laboratory in 1982. The major vector of the disease was identified as the black-legged deer tick, *Ixodes scapularis*. This tick is often also referred to in the literature as the Bear tick or the black legged tick. Lyme disease is most prevalent in the summer and peaks from May to June. This disease has been reported from all 50 of the United States and in 1996, 14,456 cases were reported to the CDC. The two current geographic foci, the northeast and northwest U.S., account for approximately 95% of the reported cases. The eight northeastern states of Connecticut, Delaware, Maryland, New Jersey, New York, Pennsylvania, Rhode Island and Wisconsin alone account for 90% of the cases of Lyme disease reported to the CDC. Lyme disease appears to be migrating south along the Atlantic coast. Only one case of Lyme disease had been reported to the Virginia Health Department through 1995, however, eight cases were reported in 1996 and another 20 were reported in 1997.<sup>8</sup> These reports are especially interesting because Virginia does not have heavy concentrations of the deer tick, indicating that other

species of ticks may also be involved in Lyme disease transmission. Other researchers<sup>9</sup> have isolated *B. burgdorferi* spirochetes from ticks found parasitizing numerous species of birds collected in Georgia. Consequently, some migratory bird species may be important in the dispersal of Lyme disease. In the western coastal states of northern California and Oregon, the primary vector of Lyme disease is the Pacific or Western black legged tick, *Ixodes pacificus*. In the northeast, transmission of the spirochete during the summer is accomplished primarily by the bite of the nymph form of *Ixodes scapularis*. Adult *Ixodes* are also capable of transmitting *Borrelia* but are more active during the fall and winter and are typically felt and removed before they can transmit disease. It is currently speculated that ticks must be attached for a minimum of 12 to 24 hours before sufficient numbers of the spirochete can be transmitted to cause disease.

Although cases of Lyme disease have been reported from the south, the total number of cases remains low, in spite of the existence of the tick vector and large populations of the reservoir species recognized from the northeast, and other southern states. These reservoir species include the whitetail deer (*Odocoileus virginianus*) and<sup>10</sup> the raccoon (*Procyon lotor*). Other reservoir species include the cotton mouse (*Peromyscus gossypinus*), the white footed mouse (*Peromyscus leucopus*) and<sup>11</sup> the cotton rat (*Sigmodon hispidus*). Another potential vector in the south is the Lone Star tick (*Amblyomma americanum*). Although *B. burgdorferi* has been shown to be present in the Lone Star tick, the CDC has not been able to definitely establish vector status for this tick. Masters et al.<sup>12</sup>, however, reported the culture of *B. burgdorferi* from a Lone Star tick and speculated that the species may be a bridge vector for Lyme disease.

### Lyme disease - A Mississippi Problem?

Researchers at the Vector Ecology Laboratory of Fordham University in New York have shown a relationship between peak nymph activity and numbers of Lyme disease cases.<sup>13</sup> Of significance, no Lyme disease cases were noted during the first four months of the year when nymphal forms were inactive. The nymphs of several of the fifteen species of Mississippi ticks are known to routinely feed on human beings. Interestingly, in approximately 7 or 8 years of examining ticks sent to the Mississippi Department of Health, Dr. Jerome Goddard (personal communication) has identified only one *Ixodes scapularis* nymph that was found feeding on its human host. *Ixodes scapularis* nymphs in the southeastern United States apparently feed primarily on skinks and

lizards and not the typical reservoir species found in the northeastern U.S. These biological factors may help explain why Lyme disease seems to occur only rarely in Mississippi. Of interest, however, German researchers have been unable to demonstrate that nymphal ticks of the three primary Lyme genospecies have a preference for different, specific rodent hosts.<sup>14</sup> Their study illustrated that the three main Lyme genospecies all share common rodent hosts. Studies by Hall et al.<sup>15</sup> have indicated that *Ixodes cookei* and *Ixodes dentatus* have been found to carry *B. burgdorferi* in West Virginia, indicating that other tick species may also be vectors for this debilitating disease.

Annually, only about 20 cases are reported to the Centers for Disease Control (CDC) from Mississippi<sup>16</sup> and as of 1996, a total of only 46 cases of Lyme disease had been reported from Mississippi. Antidotal evidence (personal communication with physicians and patients) suggests a much higher infection rate than has been reported. Mississippi is largely a rural state with a heavy logging industry. Many of its citizens subsist at poverty levels, and lack access to appropriate medical care. Some citizens are hesitant to seek medical care for "routine" illnesses because of the financial burden associated with the physician's office visit and with that associated with the purchase of prescription medications. Given these factors, there exists a potential for significant morbidity associated with undiagnosed Lyme disease in Mississippi if present in higher numbers than suspected.

Current CDC guidelines do not include the routine treatment with antibiotics of patients bitten by ticks in Mississippi and also do not advocate the LYMErix (Smithkline Beecham) vaccination of Mississippi patients with outdoor occupations. These recommendations are in part due to the low numbers of Mississippi Lyme disease cases reported to the CDC. Researchers at the CDC (personal communication) have been unable to identify significant numbers of *Borrelia* infected *Ixodes* ticks in Mississippi. They have also been unable to culture *B. burgdorferi* from the rash associated with southern tick bites. CDC researchers have, however, tentatively identified a new species, *B. lonestari* that is speculated to cause the EM-like rash noted in some tick bite patients in the southern United States. It is difficult to accurately and reliably identify *B. burgdorferi* from human tissue. Consequently, some investigators<sup>17</sup> are utilizing real time polymerase chain reaction (PCR) in an attempt to better identify the infection of human tissue with the *B. burgdorferi* spirochete. Their preliminary results indicated a fairly close correlation between spirochetal tissue burden and clinical symptoms.

## Laboratory Diagnosis of Lyme Disease

Patients who present with EM-like rashes and who have had potential tick bites are candidates for serological testing for Lyme disease. EM typically develops within a month post bite. This is followed by the development of IgM antibodies that may be detected by enzyme-linked immunosorbent assays (ELISA) testing. IgG antibody formation follows the appearance of IgM. The currently available ELISA tests are unable to differentiate between infected and vaccinated individuals.<sup>18</sup> The past history of several diseases, i.e., varicella, mononucleosis, some rheumatic diseases and other spirochetes (syphilis) may result in a false positive ELISA test. These test results can be clarified by Immunoblot testing. Confirmation of infection is indicated by positive IgG antibody Immunoblot tests.<sup>19</sup> Patients that are diagnosed with neuroborreliosis are also evaluated with a comparison between CSF and serum antibody levels. This comparison gives additional information on the CNS production of antibodies and may be useful in directing treatment. The most specific diagnostic test is the culture of *Borrelia* from the EM rash. Skin samples may be cultured utilizing a modified BSK-H medium.<sup>20</sup> Spirochetes may be identified from skin biopsies stained with Warthin-Starry silver stain. Skin biopsies from both the periphery and the central clearing of EM are equally productive in isolating *Borrelia*.<sup>21</sup>

## Treatment of Lyme Disease

Current antibiotic regimens for the treatment of early Lyme disease include 10 to 30 day courses of amoxicillin, amoxicillin with probenecid, doxycycline or tetracycline and cefuroxime axetil where indicated.<sup>22</sup> Lyme induced arthritis should be treated for 30 days. Patients with cardiac involvement should also receive anti-inflammatory medications. A four or five day tapering dose of prednisone should be administered to patients with cardiac abnormalities.<sup>23</sup> Lyme neuroborreliosis requires treatment with intravenous ceftriaxone or penicillin G for a minimum of two weeks to four weeks.

## Avoidance of Lyme Disease

Lyme disease is typically contracted after exposure to infected ticks when working in the yard, hiking, camping, bird watching, or otherwise engaged in outdoor activities. Individuals involved in the logging and construction industries are also at risk for contracting Lyme disease. When involved in outdoor activities in tick infested areas it is important to periodically perform tick checks. Identified ticks should be immediately removed. Long pants tucked into socks may help prevent tick

attachment to the legs and torso. Shirts should be tucked in and tick repellants should be applied to both the clothing and any exposed skin. It is not advisable to spray tick repellants on the face. A small amount of the repellant may be sprayed onto the hands and then transferred to the face by gently rubbing the hands along the side of the face. Care should be taken to avoid inhaling and to avoid contaminating the eyes with the repellent. White or lighter colored clothing facilitates the spotting of the darker colored tick against a light background. Ticks should not be touched by hand and should be removed by gently grasping the tick behind the head with a small forceps or tweezers. Gentle traction will usually remove the tick. Care should be taken to avoid application of pressure to the abdomen of the tick as this may cause regurgitation. It is also not advisable to attempt to remove ticks by the application of heat, burning matches, Vaseline, alcohol or other home remedies to the tick. These methods often cause regurgitation of the ticks stomach contents and may facilitate infection.

The encroachment of human habitation into "new" areas brings humans into contact with ticks. An important method of decreasing the potential for tick exposure that cannot be overemphasized is the removal of brush and debris from the yard and the avoidance of feeding wildlife that may bring ticks into the area surrounding human habitats. Ticks do not crawl into yards but are brought into areas by deer, rodents, other mammals, some reptiles and many birds. The removal of brush and debris from the yard and surrounding area decreases the nesting area available for small rodents and thereby decreases the numbers of associated ticks. Family pets may be protected against infestation with ticks by the application of "Front Line" (Merial), a thick viscous mixture containing fipronil. Front line is generally effective against ticks and fleas for approximately three to four months and may be purchased from most Veterinarians. Another method of controlling tick populations is through the use of insecticides (permethrin) or repellants (DEET, indalone, dimethyl phthalate, dimethyl carbate, M-1960) around the house and by making the area around the home more inhospitable. Ticks will desiccate in hot dry areas. Care should be taken to keep the yard cut, manicured and weeded thereby decreasing the micro-environmental humidity and shade.

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# Abstracts from the Mississippi American College of Physicians Associates' Meeting

*The following abstracts presented at the Mississippi American College of Physicians Associates' Annual Meeting represent the third of a three-part series published in the JOURNAL MSMA.*

—ED.

## The Electrodiagnostic Features of Certain Lower Trunk Lesions Are Pathognomonic

Captain Mauro Quaglia (ACP Associate)  
Major Mark A. Ferrante (ACP Member)  
Keesler AFB, Mississippi

**Introduction:** We describe two cases of lower trunk (LT) brachial plexus (BP) lesions, both with unique features and pathognomonic electrodiagnostic (EDX) manifestations. These lesions are anterior primary ramus (APR) lesions predominantly affecting either the C8 or TI APR. Their EDX manifestations are the obverse of each other.

**First Case - True Neurogenic Thoracic Outlet Syndrome (TN-TOS):** A 26-year-old female complaining of aching of the medial aspect of the arm for approximately 10 years and, more recently, intermittent numbness of the medial forearm and hand in the supine position. The EDX examination revealed an abnormal Uln-D5 SNAP (60% amplitude decrease) and an abnormal medial ante-brachial cutaneous (MABC) SNAP (no response) suggesting either a medial cord or lower trunk lesion. The median CMAP (APB) was severely abnormal whereas the ulnar CMAPs (ADM and FDI) were normal. This pattern, in which the MABC SNAP is more affected than the Uln-D5 SNAP and the median CMAP is more affected than the ulnar CMAPs is pathognomonic of TN-TOS, a disorder

which predominantly affects the TI APR.

**Second Case - Post-Median Sternotomy Brachial Plexopathy (PMSBP):** A 71-year-old male patient complaining of numbness of the medial aspect of the right hand and hand weakness following median sternotomy. The Uln-D5 SNAP was absent, whereas the MABC SNAP was normal. The ulnar CMAPs (ADM, FDI) were both severely reduced in amplitude, whereas the medial CMAP (APB) was normal. This pattern, in which the ulnar sensory and motor responses are both abnormal, whereas the MABC SNAP and median CMAP (APB) are normal, although suggestive of an ulnar mononeuropathy, is actually a PMSBP, a disorder which predominantly affects the C8 APR. The radial-innervated C8 muscles (i.e., EIP, EPB) help differentiate between these two possibilities.

**Conclusions:** These two LTBP lesions actually affect the more proximally located APR; their EDX patterns are the obverse of each other. Their recognition identifies surgical (RN-TOS) and nonsurgical (PMSBP) cases.

# Omeprazole As A Cause Of Acute Pancreatitis With Associated Acute Renal Failure

David Bahrami, M.D. (Associate)

Errol D. Crook, M.D., Department of Medicine, University of Mississippi Medical Center and Jackson Veterans Administration Medical Center, Jackson, Mississippi

Acute pancreatitis frequently occurs as a result of alcohol, cholelithiasis, and drugs. Presented here is an unusual case of pancreatitis temporally associated with omeprazole, a drug not previously associated with pancreatitis. A 41 year old black female with a history of Type II diabetes mellitus and hypertension presented to a local hospital complaining of abdominal pain, nausea, vomiting, and decreased appetite for two weeks. Two weeks prior to this admission, the patient had presented complaining of epigastric pain and was treated for gastritis with omeprazole 20 mg PO QD. She denied any history of alcohol abuse, hepatitis, or pancreatitis. Her other medications were: Glucotrol XL 5 mg PO QD, Lotensin/HCTZ 10/12.5 mg PO QD, Norvasc 5 mg PO QD, and Aspirin 325 mg PO QD and these were not changed at that time. Laboratory data from initial visit were significant for white blood cell count of 9600; hematocrit of 34.1%; mean cell corpuscular volume of 90.3 FL; platelet count of 292,000; blood urea nitrogen of 27 mg/dL; creatinine of 1.9 mg/dL; glucose of 333 mg/dL; and normal liver function tests. Two weeks later, she presented complaining of abdominal pain, nausea, vomiting, and decreased appetite for about two weeks with decreased urine output for about 48 hours. Laboratory data revealed a blood urea nitrogen of 137 mg/dL, creatinine of 19.2 mg/dL, and patient was transferred to University of Mississippi Medical Center for further care.

**PHYSICAL EXAMINATION:** T 96.1 HR 106 RR 24 BP 108/61. She was a middle aged black female in mild distress. She was oriented only to time and place. There was a II/VI blowing systolic ejection murmur located at LLSB with no radiation. Pulmonary exam revealed bibasler rales. Her abdomen was non tender, non distended, with normoactive bowel sounds, no hepatosplenomegaly by palpation, no guarding or rebound. There was +1 bilateral lower extremity pitting edema.

**LABORATORY DATA:** CBC revealed a white blood cell count of 13,100 with 81.0% segmented neutrophils; hematocrit of 25.8%; and normal platelets. Serum chemistry revealed a sodium of 135 mg/dL, potassium of 4.2 mol/L, chloride of 104 mole/L, bicarbonate of 14 mol/L, blood urea nitrogen of 94 mg/dL, creatinine of 11.3 mg/dL, glucose of 172 mg/dL, calcium of 8.4 mg/dL, albumin of 2.9 g/dL, magnesium of 1.0 meq/L, phosphorus of 3.1 g/dL, alkaline phosphatase of 108 U/L, total bilirubin of 0.99 mg/dL, ALT of 11 U/L, AST of 18 U/L, CPK of 93 U/L, amylase of 338 U/L, and lipase of 5428 U/L. Serum alcohol level was less than 10 mg/dL. Triglyceride level was 373 mg/dL. Urine drug screen was negative. Serum osmolality was 311 mosm/kg. Urine Analysis revealed trace protein, few hyaline casts, granular casts, no red blood cells, and no white blood cells. Sonogram of gall bladder, liver, pancreas was unremarkable. Renal sonogram revealed no hydronephrosis. Right kidney was 9.7 cm and the left kidney was 10.0 cm.

**DISCUSSION:** A diagnoses of acute pancreatitis with associated acute renal failure was made. The patient required emergent dialysis due to uremic mental status changes. Her acute renal failure after 4 days had resolved with volume replacement. The patient's pancreatitis resolved with the discontinuation of omeprazole and bowel rest. After reviewing this patient's hospital records omeprazole was felt to be the precipitating factor for pancreatitis. A review of the literature reveals no reported cases of pancreatitis secondary to omeprazole. However, the Physicians Desk Reference states omeprazole can cause fatal pancreatitis. Astra Merck Pharmaceutical, the producer of omeprazole, reports that there have only been two other known cases of pancreatitis attributed to omeprazole. Acute renal failure is a relatively common complication associated with a dismal prognosis in the patients with severe pancreatitis. The factors associated with acute renal failure in pancreatitis will be discussed.

# Ideopathic Muscle Infarction in A Patient With Long-Standing, Poorly Controlled Diabetes Mellitus

Christopher W. Roney, M.D., (Associate)

James Warnock, M.D.

University of Mississippi Medical Center

Diabetic muscle infarction is a rare yet well-described complication of poorly controlled diabetes mellitus. Most patients have a history of microvascular disease, including retinopathy, nephropathy, and neuropathy. It was first described by Angervall et al in 1965 as "tumoriform focal muscular degeneration", and since, fewer than 30 cases have been described in the English literature. Patients usually present with the insidious onset of a painful lower extremity mass (usually of the thigh, but calf has been reported). Biopsy shows necrosis with areas of regeneration without signs of infection or malignancy. Pathology normally resolves with conservative management in several weeks.

**Case:** A 35 year old male with history of insulin-requiring diabetes mellitus under poor control, hypertension, nephropathy, and retinopathy was admitted for evaluation and therapy for severe right "hip" pain. Patient was found to have an area of erythema and induration measuring approximately 4 x 4 cm over lateral aspect of right thigh which was extremely tender to palpation with an adjacent small, healing ulceration. Patient was afebrile with leukocyte count of 14,000 and initial CPK of 1185. Antibiotic therapy for presumed infection was initiated with Ampicillin/sulbactam and an MRI was performed to assess the affected area. The MRI showed no evidence of focal abscess or fluid collection but did indicate nonspecific myositis involving the gluteus maximus and adductor magnus muscles. At that time, needle biopsy was performed which showed fibroadipose tissue with perivascular inflammation. All cultures obtained from thigh and blood were negative, and patient showed little improvement on expanded antibiotic coverage including Vancomycin, Clindamycin, Gentamycin, and

Ceftazidime. Subsequently, open muscle biopsy was performed which showed recent infarct of muscle with fiber regeneration, inflammatory cell infiltration and vessels with narrowed lumens and thickened endothelial walls. Secondary to biopsy findings, antibiotic therapy was discontinued, and patient was discharged home with slight improvement of symptoms.

The pathophysiology of diabetic muscle infarction is, as of yet, unclear, but various investigators have implicated microvascular disease and/or coagulation abnormalities. The muscle groups most commonly affected include the quadriceps, thigh adductors and calves. The differential diagnosis includes infection, malignancy, thrombophlebitis and myositis. The best imaging modality to evaluate the lower extremity in the above situation is MRI, which shows localized tissue edema. The literature suggests that biopsy should be avoided if muscle infarction is suspected secondary to decreased healing and increased incidence of hematoma formation at the site of the biopsy. Therapy should include adequate analgesia and immobilization of the affected extremity until symptoms have subsided. Physical therapy should be avoided secondary to tendency to exacerbate pain and lengthen the time of healing. The symptoms normally spontaneously remit after a period of time, but recurrence has been noted in up to 40% of the studied individuals, often in the contralateral lower extremity.

In conclusion, diabetic patients who present with complaints of thigh pain and swelling without signs of infection, thrombus or malignancy should be carefully evaluated for idiopathic muscle infarction and biopsy avoided if possible.

# **Neutropenic Fever in Cancer Patients at Keesler Medical Center**

**Captain Joseph Amato (ACP Associate)**  
**Major Thomas W. Ratliff (ACP Member)**  
**Major Alan W. Thomas (ACP Member)**  
**Major Richard J. LoCicero**  
Keesler Medical Center, Keesler AFB, MS

**Purpose:** We studied the cancer patient population at Keesler Medical Center to determine the frequency of neutropenic fevers as well as the associated diagnoses, treatments, type of infections, and outcomes.

**Methods:** Patients in the medical oncology clinic at Keesler Medical Center receiving chemotherapy were prospectively followed from 1 January to 31 August 1997 for the development of neutropenic fever. We reviewed diagnosis, type of chemotherapy, type of infection, total number of hospital days, and outcome.

**Results:** 240 patients received cytotoxic chemotherapy during the study period. There were 10 episodes of neutropenic fever (4%). Cancer diagnoses for these patients included lung cancer (3), acute myelogenous leukemia (3), breast cancer (2), colon cancer (1), and lymphoma (1). Treatment types included cyclophosphamide, etoposide, and vincristine (1); docetaxel (1), cisplatin and vinblastine (1), idarubicin and/or cytosine arabinoside (3), doxorubicin and cyclophosphamide (2), 5-fluorouracil and leucovorin (1), and cyclophosphamide, doxorubicin, vincristine, and prednisone (1). Sources of infection included UTI (2), possible *Staph epidermidis* bacteremia (2), catheter infection (3), and unknown (3). All noted catheter infections were associated with the AML patients. Hospitalization days ranged from 4-32 with outcome including palliation (3), dose reduction of chemotherapy (2), completion of treatment (4), and no change in therapy (1).

**Conclusions:** Neutropenic fever in cancer patients receiving chemotherapy occurs with a frequency of 10-100%, depending on the type of treatment. Our neutropenic fever rate of 4% compares favorably with this. There are no associated deaths. We found no common source among our patients except for the catheter infections associated with the AML patients.

## A Message To My “Live & Then Give” Partners

**Phil Berry, MD,**  
**Past President of Texas Medical Association**

*[At the 131st annual meeting, the House of Delegates adopted Resolution No. 5 which states “the MSMA will continue to work with organ and tissue recovery agencies of Mississippi to make certain that all citizens ... are offered the option of donation of solid organs and/or tissue as appropriate.” The following information is from the Organ Donor Project of the Texas Medical Association, Texas Medical Association Alliance, Texas Transplantation Society and Texas Medical Association Foundation. —Ed.]*

I am the recipient of the greatest gift you can imagine! More than ten years ago, I was confronted with my own mortality when I learned that I had contracted hepatitis B in the operating room, that I was suffering from liver failure, and that I would surely die without a liver transplant. As an orthopaedic surgeon, those facts were in the back of my mind, but hearing the words from my own doctor made me face the awful truth.

My miracle occurred on October 27, 1986, when a 30-year-old woman from Brazoria died of a bleeding aneurysm. Her husband, small daughter, and parents knew of her wishes to be an organ donor if tragedy befell her, and they donated her organs so that I - and others - could live.

Needless to say, this experience not only gave me life - it changed my life. I look back now on the precious moments I would have missed. I rejoice more than ever in my wonderful family and my grandchildren. I appreciate my friends and my colleagues like never before. And I never forget for a moment that it might have ended differently.

What happened to me could happen to you, your husband or wife, your child, or your best friend. It has happened to the estimated 57,000 people nationwide now on the waiting list for organs, 4,000 of whom will

die because organs won't become available in time.

My experience led to my decision to make organ donorship the cornerstone of my service as president of Texas Medical Association. My heart is filled with gratitude and pride, knowing that we have it in our power to help so many people.

Thank you so very much for opening your hearts and your minds, and for your willingness to... Live & Then Give!



*Dr. Phil Berry continues to give his “Live & Then Give” presentation like shown here to students and staff at the University of Mississippi Medical Center. His message encourages you to sign your donor card and tell your family.*



## Trauma in Mississippi

**W. Briggs Hopson, Jr., M.D.  
The President's Page**

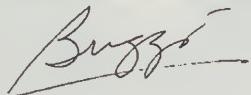
**W**ith the passage of House Bill #966 by both the House and Senate, and signed by the Governor on the 23rd of March, 1998, Mississippi finally enacted a law giving the State Board of Health and the Division of Emergency Medical Services the authority to issue rules and regulations for administering a uniform statewide trauma care system and to receive and distribute Mississippi trauma care system funds to all hospitals and physicians who participate in the development and provision of trauma care to the citizens of Mississippi. The legislature allowed the Department of Health to develop rules and regulations that include trauma system plans, trauma system standards, trauma center designations, field triage, trauma transfer, aeromedical transportation, trauma date collection, trauma care systems evaluation, and management of state trauma system funding. However, notwithstanding, the legislature also has allowed the State Board of Health the ability to work on trauma education, trauma prevention and rehabilitation, knowing any trauma prevented is a traumatic occurrence that does not have to be cared for nor paid for.

The Emergency Medical Services Advisory Committee was expanded by eleven members, all who are appointed by the Governor. The new members consisted of one licensed physician from each of the regions designated by the State Board of Health, one registered nurse to be appointed from a list of nominees submitted by the Mississippi Emergency Nurses' Association, one EMT paramedic whose employer renders emergency medical services in a designated trauma care region, one representative from the Mississippi Department of Rehabilitation Services, one member being a person who has been a recipient of trauma care or who has an immediate family member who has been a recipient of trauma care in Mississippi, and one licensed neurosurgeon to be appointed from a list of nominees presented by the Mississippi State Medical Association.

With the passage of this bill, the Mississippi legislature appropriated funding by increasing the traffic violation penalty and increasing the implied consent law violations. It was estimated that the income from these two sources would be approximately 2 to 2 1/2 million dollars per year. This was less than the original 8 million dollars that the Division of Emergency Medical Services, State Board of Health had applied for. Last year the legislature in its wisdom set up an additional 6 million dollars to fund uncompensated trauma care.

Since its enactment, a number of things have happened. The Division of Emergency Medical Services brought in three national consultants who discussed overall planning for the State of Mississippi with regard to trauma care. These consultants met with individuals on the Gulf Coast, Hattiesburg, Jackson, Greenwood, and Tupelo, giving guidance as to setting up systems within these regions. At the present time, regionalization is beginning to take place. It is our hope that all areas will begin having meetings to bring the hospitals, as well as physicians, together who will work on developing guidelines that can be submitted to the Trauma Advisory Committee as it continues developing overall state guidelines.

As we all work to collect more meaningful data, the Committee will continue to lead Trauma Care in our state. All of our citizens deserve first-rate trauma care. They get first-rate prehospital care. Soon they will get outstanding total system care.



## MSMA 132nd Annual Session

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## GOODBYE TO MISSISSIPPI'S GOOD OLD BOY: WILLIE MORRIS

"Big man, little boy combo," was how writer Will Campbell described his friend Willie Morris, Mississippi's celebrated writer, at the latter's funeral in Yazoo City. Of all the comments at the funeral, Campbell's seem to touch the core of Willie Morris the person and the writer. His genius dripped from most of his well-chosen words, but in describing the Southern boyhood Morris was especially talented.

The gifted Morris surprised many of us when he died suddenly August 2, 1999 at St. Dominic's Hospital in Jackson of an apparent heart attack. The famed author, who was 64, had been taken to the hospital earlier in the day with shortness of breath. "Willie didn't like doctors or hospitals," commented his longtime friend Dr. Verner Holmes, "I knew he must have been ill when he stayed at St. Dominic's." His death shocked many in the state, who seemed unprepared to mourn this beloved man of letters. Morris's body lay in state in the rotunda of the Old Capitol; he was the first writer ever to lie in state there, with hundreds of people flowing about his closed dark-wood coffin, covered with white lilies. Later in the day his body went north towards home, up Medgar Evers Boulevard to Yazoo City, to be buried in the old section of historic Glenwood Cemetery, just two plots due south of the infamous "Witch of Yazoo's grave" (with a chain encircling it, just as Willie had written).

Morris was born in Jackson on November 29, 1934, and at six months of age his family moved to Yazoo City, which became for him what Hannibal, Missouri was for Mark Twain, the source of inspiration for much of his fiction and writing. After graduation from high school in Yazoo City, Morris journeyed to the University of Texas at Austin, where he studied under respected English professor Frank Lyell and served as editor of the student newspaper. He studied in Oxford, England as a Rhodes Scholar and returned to America to become associate editor at *Harper's Magazine*, the nation's oldest magazine. In 1967, he became the youngest editor-in-chief ever of the illustrious magazine.

In 1980, Morris returned to Mississippi as writer-in-residence at Ole Miss, teaching his craft to a decade of student writers. He left Oxford for the banks of the Bogue Chitto River, spending almost three years in Pike County in the 1980s.

In 1990, he married JoAnne Prichard, a talented editor at University of Mississippi Press. Besides a mutual love of the written word, they shared much, including Yazoo City roots and a love of Ole Miss. They made their home on Brookdale Street in Jackson, where he was living at the time of his death.

He wrote more than a dozen books of fiction, essays, memoirs, and history. Some of these included *North Towards Home* (1967), *The Courting of Marcus Dupree* (1983), *Good Old Boy* (1971), *Good Old Boy and the Witch of Yazoo* (1989), *The Ghosts of Medgar Evers* (1998) and *New York Days* (1993). He never stopped exploring the South and its people, lucidly expressing what he called "the old warring impulses of one's sensibility to be both Southern and American."

Despite Willie's inherent dislike of physicians, or at least going to see them, one of his closest friends throughout the last 25 years of his life was the legendary Pike County otolaryngologist, Dr. Verner Holmes, now 90, who lives in Jackson. Morris published in 1989 a collection of essays called *Homecomings*, with the art of his friend William Dunlap. The dedication page reads: "to Verner Holmes of McComb and downtown Lexie, to Vern Holmes of the Bogue Chitto, and to Susanne Dietzel and Dave R.—whose friendship runs deep as the Bogue Chitto itself." The dedication clarifies this close connection between Holmes and Morris (and Holmes was Morris's connection to the Bogue Chitto River).

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

The story of the doctor and the writer is an interesting one. Dr. Holmes, a Walthall County native, had long served on the Board of Trustees of the Institutions of Higher Learning. A mutual friend, respected Ole Miss historian David Sansing, now a retired professor emeritus of history, introduced Holmes to Morris, who had returned to Ole Miss as writer-in-residence. The three would go to football games together, and soon Verner's namesake son Vern joined the group.

The group came to be known as "The South End-zone Bleacher Bums." They would regularly claim the low priced seats in the south end-zone at home games at Ole Miss. Eventually joining the happy group were Dean Faulkner Wells (Faulkner's niece and owner of the Yoknapatawpha Press, which published some of Willie's books), her husband author Larry Wells, Ron Bourne, and others.

After several years of friendship, Willie told Dr. Holmes that he would be leaving Ole Miss to work on a novel. Holmes invited him to come down to live and write at his three-decade-old pecky cypress house on the Bogue Chitto River, located on Highway 44 at Quin's Bridge, near Friendship Church. (This same house was featured in WTBS's *Portrait of America* series) Willie came down, got to work, and stayed a full two and a half years on the banks of the river in the 1980s.



Willie Morris here speaks on his friend Eudora Welty at Lemuria Bookstore in April. This photo was taken just a few months before his sudden death in August.

wanted to invite him up for a visit to Washington."

Vern Holmes recalls that Morris's book *Good Old Boy and the Witch of Yazoo* was conceived and written in Pike County: "When mother (Mrs. Emma Holmes) died, the Holmes family and Willie gathered around the kitchen table on Lissa Drive after the graveside service. It was there that the book *Good Old Boy and the Witch of Yazoo* was born. My niece Lyn Covington of McComb contributed the idea and Willie started the outline for the book there at the table." Vern notes as well that Willie began work on the novel that would become *My Dog Skip* at the river-house. "He talked a lot about his dog," said Dr. Holmes. It was also on the Bogue Chitto River that Willie, a long-time lover of dogs, fell in love with cats. "A black cat showed up at the river," said Vern, "I named him Bauer after my grandfather on my mother's side (Dr. Henry Louis Bauer of McComb). Willie fell in love with this cat." Willie later got a cat of his own, and his forthcoming book is a salute to cats called *My Cat Spit McGee*.

Morris visited all over the southwest Mississippi area with his friends, heading to Dr. Holmes's "hometown," the Walthall County community of Lexie located south of Tylertown. He ventured to historic China Grove Church and Tylertown. He spoke to elementary school classes in McComb about writing. He commented at the time to the *Tylertown Times* about writing on the Bogue Chitto: "It's a good, quiet place to work...the people are friendly...and there are good

For most of his period in Pike County, Morris worked on a book called "Taps," centered on the Korean War period, which has yet to be published. He also worked on short stories, essays, and magazine articles. Said Vern Holmes of Morris: "He would sit on the enclosed back porch and write at a table looking out on a cutoff of the Bogue Chitto River. He wrote on clean white paper with his black felt-tip pen. He had given up the typewriter, and using the felt-tip pen he felt a connection between what he was doing—a sense of flow from his brain to the words, a connection between the creation of words to his hand and the pen." Once Willie had written a stack of manuscript, said Vern, he would send the text to typists to get a typewritten, hard copy.

"One time I answered the telephone at the river-house," said Vern who lived with Willie during this period, "It was the White House. President Bush

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places to go at night."

His friend Vern Holmes recalled those good places to go: "We used to go to Dixie Springs Café all the time for supper. He liked to get a good steak. On Sundays there was a group of us that would meet at the China Palace on Delaware. Our group was called the 'Ming Dynasty Cotillion and Discussion Group.'" The group consisted of Willie, Vern, Ralph Smith (owner of Skinny's restaurant at Osyka) and others.

"He loved the time he spent in Pike County and treasured the friends he made. No one closed in on him while he was down here," said Vern.

"Pike County became a part of Willie's heart," said Vern. "He always carried great memories of his time there. He enjoyed great creativity there. He never lost the perspective that a child has of the wonder of the world. And his understanding of that wonder was imparted to others in his written works," continued Vern. The Bogue Chitto river-house was given to Verner's son Vern at the elder's retirement, and it was just recently sold out of the family.

The bond with the Holmes family persisted for the rest of Willie's life. Just recently Willie attended Dr. Holmes's 90<sup>th</sup> birthday party in Jackson. "Willie was there and looked great," remembered Vern. Willie told the family at the party that he was happy at work on a new project with his son David Rae Morris, a photographer of New Orleans, writing the text for a book of photographs of Mississippi.

This associate editor was lucky enough to know Willie's sweet and generous spirit. I remember a story he told me several months before his death of an auto ride he took one Sunday afternoon with his wife and writer Eudora Welty. Driving down forgotten dirt and gravel roads in kudzu-enveloped terrain, the three peered down a dark and desolate byway that intersected the lonely road they were on. They saw a sign naming the byway "Paradise Road." Willie laughed as he told Eudora's response as to whether they should turn down Paradise Road: "We'd be fools if we didn't," she said.

Morris took us often down Paradise Roads of all sorts. He was an inspirational teacher to one of my closest friends, C. W. "Trey" Emerson, III, M. D., who took time off from medical school to study writing under Morris during the latter's teaching days at Ole Miss in 1989. Emerson, a Mississippi native and editor of *Avocation of Compassion* (a collection of Mississippi physician verse), today practices occupational medicine in Kentucky. He much admired Morris, and that comes through in this beautiful poem he wrote:

### Watching Willie Drink

This good old boy begins with a beer,  
domestic, of course, and finishes,  
It before the tepid barroom can free  
The frosted prisoner in his hand. Soon,  
the cool liquid pardons his mind from  
the sentence of thought and dark  
eyes slowly web red.  
Clumsy fingers fumble  
a cheap orange plastic lighter  
but not a pen; his  
Writing is groomed by fastidious fingers.  
Massive arms, no,  
massive man, in a teal knit shirt  
makes the chair groan for freedom, the slump  
Becomes obvious, elbows  
feel the force, table  
shares the common burden.  
Beer, wine, bourbon...  
Coffee.  
He has stopped; tonight, he burns  
and conviction wins.  
Tonight he will feel, and write.



The body of famed writer Willie Morris is carried to its final resting place in Yazoo City's historic Glenwood Cemetery, just yards from the infamous grave of the "Witch of Yazoo," which he made so famous.

Trey's poem brings one close to a treasured evening with Willie in Oxford. Willie had his demons, as we all do, but his lyrical gifts always triumphed. He would burn with conviction. He would write with great passion and beauty. This brilliant man who so cherished our tormented and lovely state would touch us as doctors and as Mississippians. His life and written legacy show the power of words to comfort us, to inspire us, and to give our nights fire.

— *Lucius Lampton, M.D.  
Associate Editor*



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# **Initiative No. 9: For and Against Term Limits**

**Randy H. Russell, M.D.**

**Citizen Sponsor of Record, Initiative No. 9**

**Co-chairman, Mississippi Citizens for Legislative Term Limits**

**P**ro: Term Limits Help Level the Political/Governmental Balance of Power in Our State

As physicians, we are well aware of the duties and responsibilities being a member of our profession entails; on November 2nd we will have the duty and responsibility as citizens to cast an informed vote on a fundamental reform of our state government. Initiative No. 9 is only the second citizen initiative to ever qualify for the ballot in the state of Mississippi. It proposes to place a two consecutive term limit on state legislators.

This proposal would not prevent legislators who have already served two consecutive terms from running for the same seat after sitting out one term, or from running for a seat in the opposite chamber. This negates the argument that experienced legislators would be prevented from serving in the legislature; they would, however, be required to intermittently give up their overwhelming incumbency advantage which allowed 92.5% of incumbents seeking reelection in 1995 to be reelected, many with no opponent.

This proposal would also help level the political/governmental balance of power in our state, with its weak governor/strong legislature constitutional arrangement. The governor is already two term-limited, lifetime, and the lieutenant governor is two consecutive term-limited, just as this initiative proposes for state legislators.

Eighteen other states have term-limited legisla-

tures, and this reform has significantly increased the number of candidates, bringing into the process new ideas, fresh energy, and different perspectives. In California, which voted in legislative term limits in 1990, the number of lawyer legislators has decreased by one third, while the number of those with prior business experience has almost tripled.

We should logically consider the effect a term-limited legislature would have on the ability of physicians to participate more fully in state government, and compare it to the present system dominated by seniority and a small group of career-type politicians. With the current system, there has been only one physician member in the 174 member legislature since the mid-60's. This reform would make it more likely that physicians and other concerned, capable individuals would be encouraged to seek and able to attain legislative office. This system would also favor ability and leadership over seniority and political favoritism in determining the holders of key leadership roles in the legislature.

Ever had a dream where the leadership of the Mississippi Legislature included physicians? With term limits, it could happen. On November 2, 1999 cast a vote for a better legislature for all of Mississippi, vote FOR Initiative No. 9.

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*Randy H. Russell, M.D., MSMA member, is in the private practice of ophthalmology in Jackson and is a State Co-Chairman of the Mississippi Citizens for Term Limits Committee. —Ed.*

# C on: Term Limits Proposal Does Not Address the Role of "Good Legislators" or Proper Transition

**Rep. Jim Barnett, M.D.**  
**Mississippi House of Representatives**

Mississippi voters turned down a term limits proposal in 1995, by a margin of 54.3 percent to 45.7 percent. Now, the same out-of-state group of activists is pumping money into Mississippi trying to pass another term limits proposal that would limit state legislators to just two four-year terms.

Mississippi voters would be well advised not to accept this poorly designed initiative for virtually the same reasons that the 1995 proposal was rejected. You would lose the right to vote for whom you please. That's about as basic as it gets in this debate over term limits for members of the Mississippi Legislature.

No American freedom is cherished more than the right to vote for the person of your choice. That right will be severely diminished if term limits are enacted. I often wonder how Mississippi would have fared for much of the past half-century had our citizens not been able to vote all those years -- because of term limits -- for the likes of U.S. Senator John Stennis and U.S. Representatives Jamie Whitten and G.V. (Sonny) Montgomery, or, nowadays, for U.S. Senate Majority Leader Trent Lott or Senator Thad Cochran. What if these outstanding Mississippi public servants had been limited to just two terms in Congress? It is likely that the state's military bases long ago would have succumbed to federal budget cuts. Mississippi's share of the "federal pie" would likely have been much smaller. The performance and service of these statesmen are examples of what seniority has done for Mississippi that every voter can relate to -- and why the general idea of term limits can be so detrimental to a small state or to a legislative district within a state.

Limiting an elected official to just two consecutive terms, or eight years, is not good public policy and would ultimately do more harm than good because institutional

memory would be cycled out every eight years. Power would shift to lobbyists, agency heads, and legislative staff members. New elected officials would spend much of their time in office learning the ropes - legislators will tell you that it takes at least one term to learn the complicated processes. In short, there is much to be said for experience. If the only people with the knowledge of the inner workings of the \$10 billion state budget or the intricacies of health care policy are the lobbyists, agency heads, and staff members, these people will be making the critical decisions regarding our state's future. Did you get the opportunity to elect them?

The constitutional amendment also does not address the transition. The amendment would take effect on January 1, 2000. Eight years later, every state legislator would have to give up his or her office. This is a great prescription for a public policy disaster. The failure of the amendment to provide for a staggered series of term limits during the transition period is reason enough to defeat it.

Remember, term limits will result in good legislators getting weeded out indiscriminately with the bad. Do you really want to throw out your representative or state senator if they are doing a good job? Most people now believe, when the facts are truthfully put before them that it is wrong not to be able to reelect someone who is doing a good job. You can already limit an elected official who is not doing a good job by voting him out on election day.

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*Representative Jim C. Barnett, Jr., M.D. is a MSMA member who has served Brookhaven's District 92 for the last eight years. Prior to that he had served that community in the practice of family medicine and general surgery. —Ed.*

*The comments expressed in this Journal are those of the indicated author. Comments and opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit comments for publication regarding any opinion expressed or information contained in the Journal.*

# Mississippi State Board of Medical Licensure: Safe? No, But Good

**W. Joseph Burnett, M.D.**  
**Director, Mississippi State Board of Medical Licensure**

C.S. Lewis, maybe this century's greatest Christian apologist, wrote many books concerning his faith but is probably best remembered for his series of children's books, *The Chronicles of Narnia* (for children ages 6-106 years). In these books, Narnia is a fantasy land entered by the children through the back of a magic wardrobe. Susan, a little girl and the lead character in the books, in an early visit to Narnia confronts Asian for the first time. (Asian is the Great Golden Lion and Lewis' Christ figure.) She is walking along with Mr. Beaver when she sees Asian. She asks Mr. Beaver (of course, in Narnia animals can talk) "but Mr. Beaver is He safe?" And Mr. Beaver responds, "Safe? No, but he's good! He is the King of the world I tell you."

We all know bad news spreads rapidly and good news may creep. There was some inaccurate and somewhat deceptive "bad" news spread about our Mississippi State Board of Medical Licensure (MSBML) last year. An individual physician's study on Boards around the country concluded the Mississippi Board was, per capita, number one in the nation in taking disciplinary actions on the state's physicians! We have all learned, over the years, to carefully consider research data and to confirm that the study does indeed compare apples with apples, before accepting the conclusions made. That individual study, in my opinion, simply does not compare apples with apples. I have learned that regulations vary tremendously from state to state. What one state calls "disciplinary action" and is therefore reportable, another state may negotiate through a "mediation panel" and not require reporting.

I have struggled with the apparent "negative" implications of this study. But then I remember that great scene from C.S. Lewis's story--- "Is He safe?" Susan asks. Our obvious first response would be, of course not, lions are not safe. But things are not always what they seem. You may have read the study about MSBML's disciplinary reputation and thought, "of course it's not safe," but again, I challenge you to consider whether things are always what they seem.

For you as a physician, is MSBML safe? If you are

following the rules and regulations as set forth by the Board and are practicing good medicine within the bounds of the Medical Practice Act, then the answer is yes. The Board goes to every length to insure that due process is afforded each licensee who is subject to informal or formal disciplinary action. It must be understood that the statutory mandate of the Board is to protect the public. For example, a recovering physician recently relapsed. He had been publicly intoxicated for days, had a prior history of carrying and discharging a firearm, and found himself in jail. This required immediate and decisive action. He went into a treatment program and is back into a monitored program of continued sobriety that allows him to practice medicine with reasonable skill and safety. Another recent situation involved an elderly physician who was obviously impaired due to the aging process and agreed to surrender his license without any blemish on an otherwise long and productive career. These are the things that I consider to be the "positive" fall-out from the difficult job performed by the Board. It is a good situation when not only the public can be protected, but also the professional standards and reputations of the thousands of healthy physicians in our state.

Thanks to MSBML, MSMA, Caduceus Club (now Mississippi Recovering Physicians' Program) and the tireless dedication of Dr. Ellis Moffitt and other physicians' time and financial support, Mississippi is the best I know at identifying impaired physicians, getting them into treatment and accomplishing a healthy re-entry to practice.

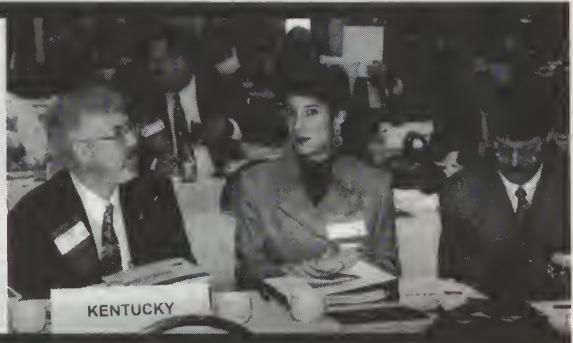
The nine members of the MSBML Board are experienced, dedicated physicians who *voluntarily* accepted an appointment by the Governor, from a slate presented the Governor by the House of Delegates of MSMA. They are us and for us.

You may think me presumptuous to associate with Lewis' Asian character, but, the more I learn about this, I can't help but sometimes think--MSBML: Safe? No, but Good. One of the best in the world, I tell you!

**American Medical Association  
Organized Medical Staff Section (AMA-OMSS)**  
*invites your medical staff to be represented at the*

**1999 Interim Assembly Meeting, December 2-6, in San Diego**

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Voice  
Victory***



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Be part of the process. Send a representative\* from your medical staff to the 1999 Interim AMA-OMSS Assembly Meeting, December 2-6, in San Diego. *There is no fee to attend.*

OMSS representatives can:

- Submit resolutions prior to the Assembly meeting.
- Testify at Reference Committee hearings and vote in the Assembly.
- Participate in special issue forums.
- Network at state and regional caucuses.
- Attend education programs. (*Topics include: managed care contracts, new CPT codes and software, preventing and managing adverse outcomes, improving physician image through community involvement, protecting your practice from embezzlement, conflict of interest policies, technology and medical staff reengineering, ways to be an effective agent for change, reestablishing collegiality in the medical profession, and federal and state legislative affairs.*)

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at [omss@ama-assn.org](mailto:omss@ama-assn.org).

\* Must be an AMA member

**American Medical Association**  
Physicians dedicated to the health of America



# Mississippi State Medical Association

## MSMA Dedicates New Building



*Left to right: George E. McGee, MD, Hattiesburg, Speaker, House of Delegates; Ben M. Carmichael, MD, Hattiesburg, Trustee; President of the Ridgeland Chamber of Commerce David Harris; John J. Cook, MD, Jackson, Trustee; W. Briggs Hopson, Jr., MD, Vicksburg, President; T. Steve Parvin, MD, Starkville, Chairman of the Board of Trustees; Candace E. Keller, MD, Hattiesburg, President-elect; William F. Roberts, MSMA Executive Director and James R. House, III, MD, Jackson, Trustee.*

The association's new headquarters building, consisting of 12,400 square feet was dedicated August 13, 1999 followed by an open house. The new headquarters building is located on 3.25 acres of land in The Quorum on Highland Colony Parkway in the city limits of Ridgeland. This site was chosen by an ad hoc committee of the Board of Trustees after reviewing numerous properties in and around the city of Jackson. Construction began in November 1998 and was completed in May 1999. The facility houses staff of the association and its wholly-owned subsidiaries, MSMA Diversified Services, Mississippi Physicians Insurance Company, and Mississippi Physicians Care Network.

In dedicating the building, MSMA President Dr. W. Briggs Hopson made the following remarks:

Many of you in the audience have built a home and probably realize that a building project is no small task. Many people have worked to complete the job of site

selection, planning, managing, and constructing our new office building and we want to recognize them as part of this dedication.

First among these are Doctors Julian Henderson, Hal Moore, Dewitt Crawford and Chester Masterson. These gentlemen made up the task force from the Board of Trustees that decided if and when we should build a new building.

Once the site had been selected and approved by the Board, the Executive Committee composed of Doctors Masterson, Parvin and Cook oversaw the planning and development of the entire construction project.

Although these dedicated physicians played a critical role, no building project of any size can be completed without the skills of those who actually design it, plan it, build it, and equip it. In this regard, I would like to recognize the following individuals ...

Speaking of the building's furnishings, I would now like to recognize and thank a few very special people whose generosity and devotion to this organization are exemplary. They contributed and/or furnished areas within our building.

The beautiful furnishings that you see in the reception area were contributed in memory of our beloved friend and colleague, Dr. Carl Evers, by his wife Jan and their children - Karen, Julie and Gustav. Their contribution to this building in honor of Carl is permanently recognized on the plaque on the far wall of the reception room.

Next, I would like to recognize a group of physicians who have devoted as much of their time and energy to this association as any group within the State of Mississippi. This group, the Mississippi Asthma and Allergy Clinic, has produced three Presidents of this association. One of these presidents, Dr. Ellis Moffitt, and his late wife, Dr. Nina Moffitt, devoted much of their lives to implementing the impaired physicians program and overseeing its operations for over 20 years. To appropriately honor the efforts of Ellis and Nina on behalf of their colleagues and patients, the Mississippi Asthma and Allergy Clinic has graciously contributed all of the furnishings in our beautiful new Board Room. For this exceptionally generous gift, I want to thank Gwen and Wilfred Cole, Jackie and Faser Triplett, Lois and Bernard Booth, Mary Sue and Don Mitchell, Susan and Jim Haltom, Virginia and Winn Walcott, and Todd Adkins.

Dr. Hopson then expounded,

As the body is the temple of the soul, so is this building the temple of the healing and feeling that goes on by physicians throughout the State of Mississippi. As I wrote in last month's editorial in the MSMA Journal, this building represents new purpose, new values, new objectives and a new future as move into a new millennium. Hopefully, this building will endure for a hundred years. However, much more important is that the art of healing, the art of caring, the art of comforting, the art of communication, and the art of cure will endure not only for a hundred years, but as long as those who practice these arts realize that it is a gift bestowed upon them by a power greater than those who practice or teach upon this earth. It is indeed a gift bestowed on them by God.

This is truly the statement that this building so graphically makes. We intend to be here for the long haul, not only surviving, but flourishing in an environment of real, measurable, tangible service to the patients and to the physicians of this state. As we see medical associations across the country showing declines in membership, it makes me proud and should make all of you proud that we continue to show an increase in our membership.

Our strategic plan states "Our envisioned future is to be an essential part of every Mississippi physician's professional life." That is what we are committed to do and with your help and with your support, we will indeed succeed, and the Mississippi State Medical Association in the year 2100 will be even stronger.

In closing, let me again thank our wonderful staff who works here every day. Their support enables us to achieve the things that we as physicians want to achieve. I, for one, know we could not do it without them. Thank you.



*Mrs. Carl G. (Jan) Evers*



*Virginia M. Crawford, MD; her father Ellis M. Moffitt, MD and his son, John E. Moffitt, MD*



*Dr. Todd Adkins, Dr. and Mrs. (Lois) Bernard Booth, Dr. and Mrs. (Mary Sue) and Don Mitchell, Dr. Virginia Crawford, Pat Shepperd, Dr. Ellis Moffitt, Gwen Cole, Dr. John Moffitt and Dr. Wilfred Cole*

## Alliances Called to B.A.T.T.L.E.

According to national statistics, an estimated 180,000 new invasive cases of breast cancer among women in the United States will occur in 1999. Given this fact, it is obvious that many women are not receiving proper breast health care, nor are they receiving educational information on how they can take an active role in their own breast health care needs. This statement is particularly accurate among women in the socio-economically advantaged and elderly populations in our state. Therefore, with this targeted audience it is the goal of the MSMAA to encourage early detection as preventative health care through a combination of education, mammography, physical examinations by a health care provider and breast self-examinations.

Breast Cancer Awareness remains one of our areas of focus for health-related programs in the MSMAA. This year we want to encourage as many Alliances as possible to conduct some type of breast cancer program. Thus, Alliances throughout the state are preparing for a B.A.T.T.L.E. (Breast cancer Awareness program To Teach Ladies Early Detection). The projects will be hosted through a partnership of area hospitals, the Alliances, the Mississippi Extension Service, the Academy of Family Physicians, the American Cancer Society and other local organizations that are concerned with fighting breast cancer. Cities planning to host events include: Louisville (September 29th); Jackson (October 5th); Winona (October 7th); Tupelo, Decatur, and Aberdeen.



County Representatives of the Mississippi Extension Service will teach breast self-examination and use breast models to show just how a lump might be discovered. These programs allow potentially life-saving information to be put into the hands of hundreds of women.

In Jackson, the fourth annual luncheon/style show will feature breast cancer survivors as the guest models to emphasize that postoperative ladies are capable of resum-

ing a normal life and appearance, contradicting the beliefs held by many. The program at Dennery's will consist of a medical update from a physician, testimony from a survivor, information on how underserved women can obtain a free mammogram and pap smear through a grant from the Centers for Disease Control (CDC), a style show and lots of health related materials and door prizes. Free tickets will be provided to women who are over forty and possess little or no medical coverage.

Breast cancer has become the most commonly diagnosed form of cancer among women in the United States. The MSMAA believes that our project can assure that a system of early detection and control of breast cancer is available to women throughout Mississippi. Once this information has been shared with all women in our state, we can expect to see an increase in the proportions of breast cancer diagnosed Stage I or earlier.

## Annual Health Plan Process Begins

The Mississippi State Department of Health develops a State Health Plan each year under the authority of Section 41-7-173(s) and Section 41-7-185(g), Mississippi Code, 1972 Annotated, as amended. The State Health Plan has three purposes: (1) to identify priority health needs in Mississippi; (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health-related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process through final adoption of the revised Plan.

The process begins each fall with a public forum generally held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the Plan or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and files the proposal with the Secretary of State. This action

initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act.

The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "final adoption" of the revised Plan. The Department files the Plan as adopted with the Secretary of State.

Staff also obtains up-to-date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the Plan. Staff compiles this information and produces a final Plan. Following approval by the Governor, the revised Plan becomes effective July 1 of each year.

## Paradigms

Shift happens, doesn't it? We get older and we change. The world around us changes, and we change. Our relationships, our work, our health all change. I.Q.H. is also changing the way we do work.

Our new contract with HCFA, which officially began August 1, 1999, represents a shift from our goals of process improvement with collaborating organizations to improvement of quality indicators (outcomes) of Mississippi's Medicare population. Our evaluation of success in the past has been the degree of improvement by collaborators involved in the Health Care Quality Improvement Program projects for Medicare beneficiaries. Over the next three years, we will be evaluated based on improvements of indicators as measured by a random sample review of claims data or medical record abstraction of the Medicare population of Mississippi. By using fairly simple but significant indicators of care that can be measured; by developing innovative projects or process facilitators that result in improvement by those who give care in our state; and by creating public awareness of the need for improvement of these indicators, I.Q.H. and the physicians/providers in Mississippi could reach those goals.

Another shift has occurred with the new program of PEPP(payment error prevention). Some of you remember our prior experiences of case review associated with payment denials, appeals, and reconsideration. We now will approach concerns from a quality improvement perspective, i.e., identify patterns, find opportunities for improvement, feed back data, establish action plans, and remeasure. All done in a sense of collaboration, not accusation. Case review will be as a last resort only.

Folks, this is where the "rubber meets the road." This is what we asked for...do PRO's/QIO's really help in

improvement of care? Can we measure our worth? With national debate regarding managed care and the assurance of continued quality despite lower payments for care, will we, as providers of health care in Mississippi, (where true capitated managed care takes a back seat to fee-for-service), demonstrate our commitment to maintaining and providing high quality of care for our patients?

As Paul Harvey has frequently stated in his radio news broadcasts, "Stay tuned, for the *rest of the story!*"

**—James S. McIlwain, M.D.  
President**

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# Mississippi Institutions and Organizations Accredited as Providers of Intrastate Continuing Medical Education

The following medical institutions or organizations have been accredited as providers of CME by the MSMA's Council on Medical Education. Accreditation is awarded in accordance with the ACCME's/MSMA's "Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education". Information concerning CME programs and activities for physicians offered by these accredited sources may be obtained by writing or calling the Director or Coordinator of CME at the individual institution or organization.

Baptist Memorial Hospital-Golden Triangle  
2520 - 5th Street North  
Columbus, MS 39701

Baptist Memorial Hospital-North MS  
2301 S. Lamar St.  
Oxford, MS 38655

Biloxi Regional Medical Center  
150 Reynoir St.  
Biloxi, MS 39530

Council on Scientific Assembly  
MS State Medical Association  
408 West Parkway Place  
Ridgeland, MS 39158

Delta Regional Medical Center  
1400 E. Union St.  
Greenville, MS 38704

Forrest General Hospital  
Mamie Street & Highway 49 South  
Hattiesburg, MS 39404

Greenwood Leflore Hospital  
1401 River Rd.  
Greenwood, MS 38930

Grenada Lake Medical Center  
960 Avent Dr.  
Grenada, MS 38901

Jeff Anderson Regional Medical Center  
2124 14th St.  
Meridian, MS 39301

King's Daughters Hospital  
300 S. Washington St.  
Greenville, MS 38702

Medical Assurance Company of MS  
735 Riverside Drive Suite 301  
Jackson, MS 39202

Memorial Hospital at Gulfport  
4500 13th St.  
Gulfport, MS 39502

Central Mississippi Medical Center  
(formerly Methodist Healthcare)  
1850 Chadwick Dr.  
Jackson, MS 39204

Mississippi Baptist Medical Center  
1225 N. State St.  
Jackson, MS 39202

MS State Department of Health/  
MS Association of Public Health Physicians  
P. O. Box 1700  
Jackson, MS 39215

Natchez Regional Medical Center  
54 Sergeant S. Prentiss Dr.  
Natchez, MS 39215

North Mississippi Medical Center  
830 S. Gloster St.  
Tupelo, MS 38801

Northwest MS Regional Medical Center  
1970 Hospital Dr.  
Clarksdale, MS 38614

Rush Foundation Hospital  
1314 19th Ave.  
Meridian, MS 39301

Singing River Hospital  
2809 Denny Ave.  
Pascagoula, MS 39581

St. Dominic-Jackson Memorial Hospital  
969 Lakeland Dr.  
Jackson, MS 39216

Wesley Medical Center  
5001 Hardy St.  
Hattiesburg, MS 39404

## **Posthumous Gift of Willie Morris' Corneas Restores Sight to Two People**

Willie Morris was immortalized for his intellect, sweetness and generosity in eulogies and obituaries nationwide. Now, the posthumous donation of the writer's corneas has restored sight to two transplant recipients.

The transplants were performed by Dr. Connie S. McCaa at the University of Mississippi Medical Center (UMC) in Jackson following Morris' August 2, 1999 death.

"Willie Morris set an example for all of us in his life of sharing and giving to others. It seems only natural now that the donation of Willie's corneas should, by example, encourage people to donate their eyes and corneas so that others might see," said Mike Flynt, Director of Donor Services for Mississippi Lions Eye & Tissue Bank in Jackson, a member of the Eye Bank Association of America.

"Dr. McCaa probably does more cornea transplants than all the other surgeons in Mississippi combined," Flynt said. Thirty-two other surgeons in the state perform such transplants. "The majority of cornea transplants also are performed at UMC," he added. At the forefront of her field, McCaa is a UMC professor of ophthalmology and biochemistry and director of UMC's corneal and refractive surgery services.

Morris' family originally donated the Jackson writer's corneas anonymously. They now agree to release his identity as a donor to raise awareness of the dire, nationwide need for cornea and eye donations.

"Willie's son, David Rae (Morris), and I never intended to make this public," said JoAnne Prichard of Jackson, Morris' wife. "But when permission was requested, we decided to release the information in hopes that more people would donate their eyes."

"We thought Willie would have really wanted to do this."

To aid the cause, Morris' two cornea recipients, John Epperson Sr. of Hazlehurst, Mississippi, and Ozie Longino of Monticello, Miss., also agreed to make their transplants public.

"Both patients' transplants are looking fine," McCaa said. Both patients had been legally blind in their treated eye, with 20/400 vision or worse not correctable with eyeglasses.

"The cornea will clear up in about 24 hours," McCaa said at the close of Longino's August 7 surgery on his left eye. "It will be up to three months before he'll see at the cornea's maximum. But it will be only about two or three weeks before he sees considerably better than he did."

By the end of August, Longino's vision had improved to 20/70 and Epperson's had improved to 20/80.

Nobody could be happier than the transplant recipients about Morris' legacy of generosity.

Epperson, whose namesake son has starred in multiple one-man shows off-Broadway in New York, knew all about Morris' literary legacy before the cornea transplant to his right eye. But Epperson had no idea whose cornea

he had received.

"That's a surprise," Epperson, 74, said after hearing about Morris' donation, a few days after his August 5 surgery. "That was nice of Willie to do that. Hopefully, I'll see real well. It's good enough now -- I can see out of it. Before, it was like looking through a big fog."

Longino, 42, who is a forklift operator for Wal-Mart, recognized Morris' name. "Oh, yes. Thanks!" he said of receiving Morris' cornea. "I want to write that down, since I have a famous cornea. I'm going to take real good care of my eye for him." A few days after surgery, Longino said his vision is "improving constantly, a little every day ... and I'm reading up on Willie Morris."

Morris is known for mentoring countless writers, both personally and as the youngest-ever editor-in-chief of Harper's magazine in New York in the 1960s. Epperson has been saying that he hopes his new tie to Morris inspires him to write a book. Hearing that, Longino said, "maybe I'll write one, too."

Morris is credited as a major influence in changing postwar literary and journalistic history. His acclaimed books include *North Toward Home*, *Good Old Boy*, *New York Days* and *My Dog Skip*, which is set to be released in January as a movie starring Kevin Bacon, Diane Lane and the dog from TV's *Frazier*.

Donated corneas may be transplanted into either eye; corneas have no left/right orientation, McCaa explained. The "window" of the eye, the cornea covers the front of the eye to transmit and focus light into the eye. "When the cornea is scarred or damaged, it can look to the patient just like a dirty windshield," she said.

She said Epperson's cornea problem was the most common cause for cornea transplants: an edema of the cornea (pseudophakic bullous keratopathy). Longino's vision was obscured by scarring from a severe Pseudomonas ulcer on his cornea, caused by an eye infection.

In addition to being a leading cornea transplant surgeon, McCaa was one of the first physicians in the nation to perform LASIK laser eye surgery. She is now in the first wave of physicians nationwide performing Intacs cornea ring implant surgery, which was approved by the U.S. Food & Drug Administration in April. McCaa as a fellow studied cornea and refractive surgery with world-renowned surgeons Dr. Herbert Kaufman and Dr. Marguerite McDonald. McCaa is listed as one of the Best Doctors in America, which is a \$2 million, two-year peer survey of practicing U.S. physicians.

"Cornea transplants are the most successful type of organ transplants, by far, which should encourage people to donate them," McCaa said.

Flynt of the Eye Bank pointed out that even people with poor vision often have healthy corneas that may be donated. Eyes and corneas are donated after death and their removal doesn't affect the body's appearance for funerals -- which often is the concern of survivors, he said. To donate your corneas or eyes, "the most important thing you can do is to tell your loved ones," he stressed. Survivors must sign a donor release.

*For more information, call the Mississippi Lions Eye & Tissue Bank at (601) 366-5362 or visit the Eye Bank Association of America's Web site at [www.restoreesight.org](http://www.restoreesight.org)*

## Personals

**Manu S. Patel, M.D.** has joined Jackson Oncology Associates, PLLC in the practice of medical oncology and hematology.

**S. Katherine Carroll, M.D.** and **Donna L. Donati, M.D.** have joined Singing River Radiology Group, PA in Pascagoula.

**Eric E. Wegener M.D.** has become associated for the practice of plastic and reconstructive surgery, cosmetic surgery, head and neck surgery and hand surgery with Phillip K. Blevins, M.D., Shelby K. Brantley, Jr., M.D., Michael E. Jabaley, M.D., Dev A. Mani-Sundaram, M.D. and Somprasong Songcharoen, M.D. of Plastic Surgery Associates in Jackson.

**Thomas A Brill, M.D.**, board certified in family medicine, member Blue Cross Key Physician Network, Mississippi Health Partners and Participating Medicare Provider has joined the Baptist Medical Clinic Network at their Byram location in Jackson.

**Rhonda Sullivan-Ford, M.D.**, has been named a Certified Diplomate of the American Board of Obstetrics and Gynecology, a designation that will extend through the year 2008. To receive the honor, Dr. Sullivan-Ford completed the required course of graduate study and clinical work, passed the board's examinations and met numerous professional standards and qualifications. Dr. Sullivan-Ford is an obstetrician and gynecologist affiliated with East Lakeland Ob-Gyn Associates in Jackson. She is

a member of the medical staff of River Oaks Health System. Dr. Sullivan-Ford received her medical degree from the University of Tennessee College of Medicine in 1992, followed by an internship and residency in the university's department of obstetrics and gynecology. She graduated magna cum laude from Murray State University with a B.S. degree in biology.

**John Bower, M.D.**, professor of medicine and director of the division of nephrology and hypertension, received the Harriet G. Williamson Memorial Award from the National Kidney Foundation at the organization's annual meeting. Named for Williamson in honor of the first endowed chair of nephrology nursing at the University of Mississippi Medical Center, the award was given to Dr. Bower "in recognition of extraordinary and exemplary contributions, over time, to patient services such as those given with kindness and generosity by Harriet G. Williamson."

**Melessa Phillips, M.D.**, professor and chair of family medicine, received the 1999 Thomas W. Johnson Award from the American Academy of Family Physicians (AAFP). The award recognizes those individuals who in the opinion of the Academy' board of directors have made an outstanding contribution to education for family practice in undergraduate graduate and continuing education spheres. The award was named for Dr. Tom Johnson, a long-time AAFP member who actively served the Tennessee chapter and

national academy before serving as director of the AAFP Division of Education from 1971-1973.

**John E. Moffitt, M.D.**, Professor and vice chairman of pediatrics and director of the allergy-immunology division in pediatrics, was selected as a regent in the American College of Allergy, Asthma and Immunology (ACAAI). **Don Q. Mitchell, M.D.**, UMC alum and clinical faculty member, assume the presidency of the organization on November 16 at the annual business meeting to be held in Chicago.

**Charles Ozborn, M.D.**, a board-certified family practice physician with Eupora Family Medical Clinic, was recently appointed assistant medical director of North Mississippi Medical Clinics. Dr. Ozborn received his medical training at the University of Mississippi School of Medicine.

**Barry Bertolet, M.D.**, a board-certified cardiologist with Cardiology Associates of North Mississippi, has been selected as the recipient of North Mississippi Medical Center's 1999 Golden Tongue Blade Award. Dr. Bertolet received the award on account of his customer service, teamwork and quality of care and leadership.

# Placement / Classified Service

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Journal MSMA Placement ads are \$2.50/line, with a 5-line minimum charge of \$12.50. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing. Items should be sent to: **Journal MSMA Placement Advertising, P.O. Box 2548, Ridgeland, MS, 39158-2548, or Fax to: 601/352-4834**

Journal MSMA Display Classified ads 1x insertion cost \$115.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge. Items should be sent to: **Classified Section, Journal MSMA, P.O. Box 2548, Ridgeland, MS, 39158-2548, or Fax to: 601/352-4834**

## PHYSICIANS NEEDED

Physicians (especially specialists such as cardiologists, ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office.

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Jackson, 853-5487

Leola Meyer (Ext.5487)



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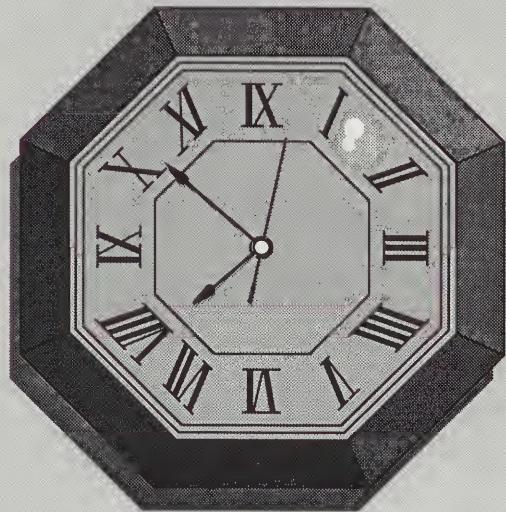
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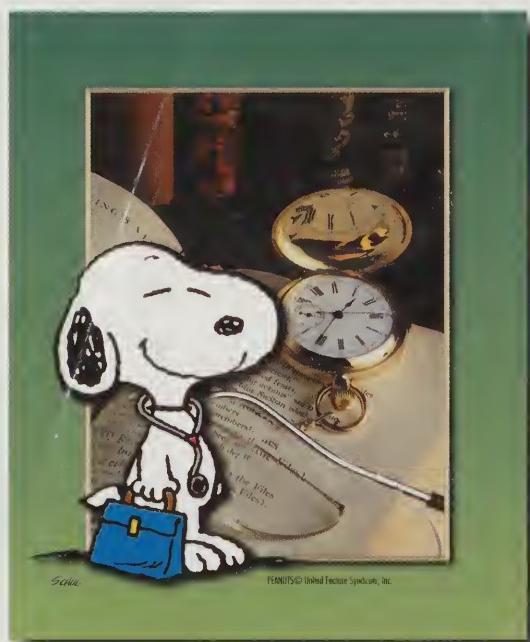
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The Acute Respiratory Distress Syndrome in Children: Recent UMMC Experience

Recognition and Treatment of Autism: The Role of the Family Physician

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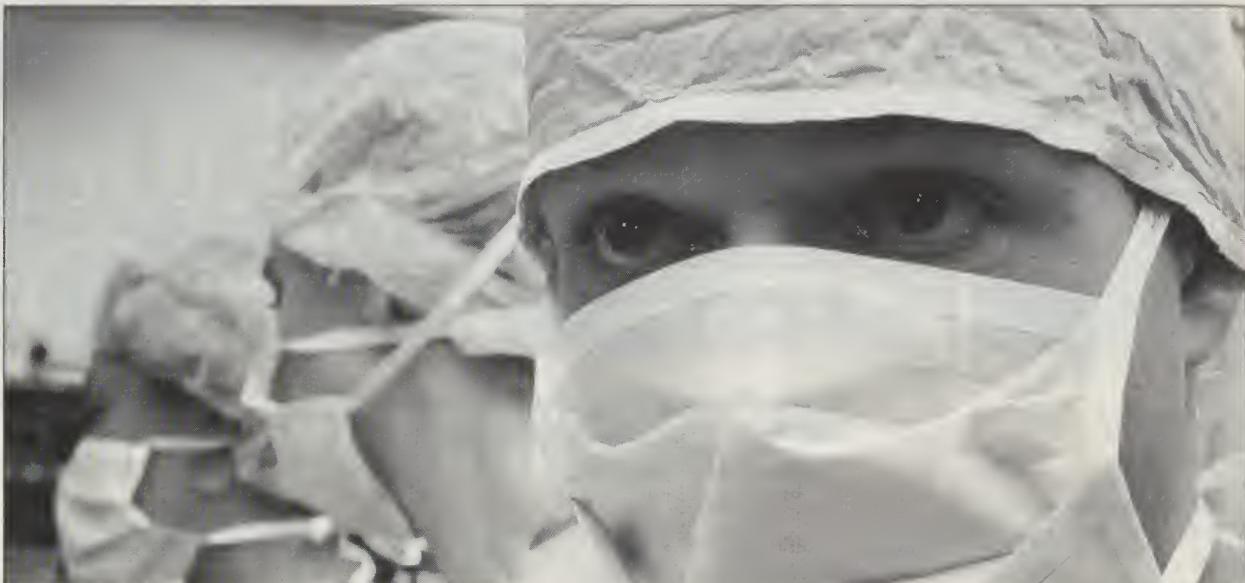
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# The Acute Respiratory Distress Syndrome in Children: Recent UMMC Experience

Thomas A. Walker, M.D.

## A bstract

The acute respiratory distress syndrome (ARDS) is now well recognized as a cause of respiratory failure in children and is associated with a high mortality rate. We retrospectively reviewed all cases of ARDS managed in our multidisciplinary pediatric intensive care unit (PICU) from 1994 to 1998 in order to identify predisposing conditions, outcomes, complications, recent trends in therapy, and resource utilization. Twenty-seven children were identified representing approximately 1% of all intensive care admissions. Sepsis was the most common predisposing illness and air leak complicated treatment in 60%. Mortality was 30% and was most often due to non-respiratory causes. High-frequency oscillatory ventilation (HFOV) was frequently utilized and felt to be beneficial in most cases. On average, survivors required mechanical ventilation for five weeks and hospitalization for nine weeks. We conclude that despite our comparatively low mortality rate, ARDS remains a significant challenge to the pediatric intensivist. We speculate that HFOV may be an important factor in reducing mortality.

**Key words:** acute respiratory distress syndrome, respiratory failure, pediatrics, high-frequency oscillatory ventilation

## Introduction

First described in 1967 by Ashbaugh et al.<sup>1</sup>, the acute respiratory distress syndrome (ARDS) remains a common cause of acute hypoxic respiratory failure in adults.<sup>2-4</sup> It wasn't until the 1980's, however, that ARDS became increasingly recognized in children.<sup>5-8</sup> As in adults, it is characterized by the onset of dyspnea, hypoxemia, reduced lung compliance and bilateral alveolar infiltrates on chest radiograph (Figure 1) that cannot be attributed to a

cardiac cause; (so called noncardiogenic pulmonary edema). Although precipitating insults may differ from adult patients, the pathophysiology is fundamentally the same. Lung injury occurs from a variety of either direct or indirect mechanisms such as pneumonia, aspiration, sepsis or trauma, disrupting the alveolar-capillary membrane and flooding the alveolus with proteinaceous fluid.<sup>9,10</sup> Despite many recent advances in critical care, mortality rates for adults and children generally exceed 50%.<sup>2,5-8,11-13</sup> Children with ARDS utilize significant intensive care resources, and survivors have relatively long hospitalizations.<sup>13,14</sup> We undertook this study to determine the outcomes, complications, and resource utilization of patients recently treated for ARDS in our pediatric intensive care unit (PICU) with the purpose of comparing these data with that available in the literature. We also examined the trend in our PICU to support ARDS patients with high-frequency oscillatory ventilation (HFOV) hypothesizing that this alternative method of mechanical ventilation may contribute to improved outcomes.

## Methods

We performed a retrospective chart review of all patients treated for ARDS at the University of Mississippi Medical Center Children's Hospital PICU during the period from July 1994 through December 1998. Eligible patients met the criteria for the diagnosis of ARDS as set forth by the recent American-European Consensus Conference on ARDS (Table 1).<sup>15</sup> Patients with congenital heart disease, chronic lung disease, or those who were managed during the acute (or later) stages of ARDS at an outside institution were excluded. In all cases, an attending pediatric intensivist supervised management. From each medical record we extracted



**Fig 1.**— Chest radiograph demonstrating bilateral alveolar infiltrates typical of ARDS. This patient is a 5 year old with sickle cell disease who developed ARDS as a complication of the acute chest syndrome.

patient age, gender, weight, presenting illness, significant previous or chronic diseases, hospital days, intensive care days, ventilator days, complications during treatment, invasive monitoring use, need for vasoactive support, use of alternative forms of respiratory support, outcome, and cause of death. Survivors were defined as those who lived to hospital discharge. All data are presented as mean  $\pm$  standard deviation (SD).

## Results

Twenty-seven patients met the criteria for the diagnosis of ARDS. The mean age was  $47 \pm 61$  months with a range of 2 months to 16 years. There were 15 males and 12 females. Nineteen patients survived to hospital discharge for an overall mortality of 30%. The mean age of survivors was  $28 \pm 43$  months versus  $92 \pm 77$  months for nonsurvivors. Seven of the 11 children with chronic illness died, whereas 15 of 16 previously healthy children survived. Predisposing conditions associated with the development of ARDS are shown in Table 2. Infectious diseases (sepsis, pneumonia) were the most frequent initiating event occurring in 70% of cases. Sepsis and aspiration each had 50% mortality while all patients with viral pneumonia survived. Death was due to intractable respiratory failure in only two cases. Causes of death in the other six cases included sepsis (2), multiple organ system dysfunction (2), and central nervous system complications (2). Nine of 19 survived without any evidence of disability. Varying degrees of chronic lung disease were present in eight patients, and three demonstrated static encephalopathy.

Air leak frequently complicated the treatment course with pneumothoraces occurring in 16 of 27 patients (Figure 2). Pneumoperitoneum was observed in three

**Table 1.— Criteria for the Diagnosis of ARDS (15):**

1.  $\text{PaO}_2/\text{FiO}_2$  ratio  $\leq 200$  (regardless of level of PEEP).
2. Bilateral infiltrates on frontal chest radiograph.
3. Pulmonary artery occlusion pressure  $\leq 18\text{mmHg}$ , when measured, or no clinical evidence of left atrial hypertension.

**Table 2.— Predisposing Conditions Associated with ARDS**

Condition	Survivors (n=19)	Nonsurvivors (n=8)
Sepsis	5	5
Viral pneumonia	7	0
Aspiration	2	2
Legionella pneumonia	1	0
Acute chest syndrome	1	0
Pulmonary hemorrhage	1	0
Near drowning	0	1
Multiple trauma	1	0
Brain tumor resection	1	0

patients and bronchopleural fistula in one. Other than tube thoracostomy, no other surgical interventions were required. Air leak was equally common in survivors and nonsurvivors.

Invasive monitoring was utilized in nearly all cases and when not, was due to technical difficulties inherent in placing these devices in small infants and children. Twenty-six patients had central venous catheters placed, and two underwent right heart catheterization. Thirteen of 19 survivors and 7 of 8 nonsurvivors required vasoactive infusion(s) for cardiovascular support.

Alternative therapies for respiratory failure were frequently employed when it was felt that patients were failing conventional mechanical ventilation (CMV) and/or had developed air leak. Twenty of 27 patients (75%) were managed at some time during their ventilator course with HFOV. Of the 19 survivors, 15 (80%) were treated with HFOV. In all but one survivor, initiation of HFOV was felt to be beneficial. The single treatment failure experienced persistent hypoxemia unresponsive to HFOV and was referred for extracorporeal membrane oxygenation (ECMO). This was the only patient referred for extracorporeal support and outcome was excellent. One patient was treated with the combination of HFOV and



**Fig 2.**— Severe ARDS complicated by air leak. Extensive subcutaneous emphysema, pneumothorax, and pneumoperitoneum shown by arrows.

nitric oxide with improved oxygenation and stability but was later removed from support.

During the study period, ARDS patients accounted for 1% of the nearly 3000 admissions to our PICU and 4% of all deaths. Total hospital, ICU, and ventilator days for patients with ARDS are shown in Table 3. Survivors were hospitalized on average for two months with ventilator and ICU days averaging five and six weeks respectively. The average length of stay in the PICU for patients with conditions other than ARDS during this same period of time was four to five days.

## Discussion

Pediatric ARDS continues to be associated with a high mortality rate. Our mortality of 30%, however, compares quite favorably with that of other pediatric

**Table 3.— Length of stay and ventilator days for patients with ARDS**

	Survivors	Nonsurvivors
Hospital days*	64 ± 54	23 ± 33
PICU days*	44 ± 40	9 ± 7
Ventilator days*	37 ± 39	8 ± 6

\*Mean ± SD

series which have shown rates to generally exceed 40%.<sup>5-8,12-14</sup> More recently, a multicenter study performed by The Pediatric Critical Care Study Group demonstrated a mortality of 43% in a group of 470 children with acute hypoxic respiratory failure of which ARDS is one cause.<sup>14</sup>

There may be several explanations for improved mortality in our series. First, there have been numerous advances in the approach to critically ill children during the past decade. These have included the growth of the subspecialty of pediatric critical care and further development of dedicated tertiary pediatric intensive care units.<sup>16-18</sup> In addition, advances in mechanical ventilation both in terms of technology and management of ARDS, with so called "lung protective" ventilation strategies may be improving outcomes by reducing pulmonary barotrauma.<sup>19</sup> It is now common practice in pediatric critical care to attempt HFOV in children with ARDS, and our use of this technique mirrors this trend. We utilize the aggressive lung recruitment strategy developed by Arnold et al. which results in improved oxygenation, allows for the use of lower peak inspiratory pressures, and limits swings in airway pressure.<sup>20</sup> Our data suggest that HFOV may improve survival in pediatric ARDS. Although limitations of this study preclude definitive conclusions on the effect of HFOV on outcomes, the data are consistent with existing multicenter data which have shown improved outcomes and a lower frequency of barotrauma when compared with CMV.<sup>21</sup>

That sepsis, aspiration, and viral pneumonia were the most common predisposing conditions to the development of ARDS is not unexpected. In two of the largest and most recent series to date by Timmons et al. and Davis et al., sepsis was the leading acute illness associated with ARDS followed closely by infectious pneumonia, aspiration, and near-drowning.<sup>12,13</sup> Our findings confirm that sepsis-related ARDS carries a high mortality. We observed a 50% mortality in this group, whereas others have seen rates in the range of 60-70%.<sup>12,13</sup> Why septic patients with ARDS are more likely to die is unclear. We do know

that sepsis and ARDS are each associated with multiple organ system failure,<sup>22</sup> and as the number of organs failing increases so too does the risk of death.<sup>23,24</sup> Compared with other series, our mortality associated with viral pneumonia was quite different. Davis et al. noted a mortality of nearly 60% in their patients with viral pneumonia and ARDS compared with a mortality of <1% in those patients with viral pneumonia who did not develop ARDS.<sup>13</sup> It is possible that the difference between their and our data lies in the definitions used for ARDS. Their study was performed prior to the Consensus Conference on ARDS<sup>15</sup> and utilized a previously widely accepted lung injury scoring system for ARDS.<sup>25</sup> Patients were included who had "severe" ARDS only based on a lung injury score. It is possible that our study included children with viral pneumonia (and other associated conditions) who developed less severe ARDS than those included in the Davis study but who met the criteria for the current definition of ARDS. With our relatively small sample population and the current broad definition of ARDS, our mortality numbers may not be appropriate for comparison with earlier series. Older definitions of ARDS applied to our data may have excluded some of our patients with "less severe ARDS" and resulted in a higher mortality rate for the series.

Pulmonary barotrauma frequently complicates the treatment of ARDS. Our 60% incidence of barotrauma is similar to that observed by others.<sup>6,12</sup> Air leak does not seem to effect survival, as it occurred as often in survivors as nonsurvivors. Although numerous reports have suggested that institution of high-frequency ventilation could prevent air leak or be utilized in the management of bronchopleural fistulae, we are unaware of any pediatric literature that specifically addresses the effect of air leak on outcome.<sup>26-28</sup> Our data are in agreement with recent findings in adults with ARDS that suggest that the presence of air leak syndrome is not associated with increased mortality.<sup>29</sup> In theory, HFOV is an attractive method of ventilatory support in patients with ARDS as it provides gas exchange with very small tidal volumes, decreasing phasic swings in airway pressure and potentially reducing barotrauma. Whether early use of HFOV would have reduced the occurrence of air leak in our patients is unknown as this ventilator technique was often employed later in the course of ARDS as a "rescue" therapy. Clinical trials examining early use of HFOV in ARDS and its effect on pulmonary barotrauma are needed to answer this question.

Although the number of children we manage with ARDS is relatively low, their use of hospital and intensive care resources is quite high. Children with ARDS made

up only 1% of all PICU admissions but accounted for 5% of all intensive care patient days. PICU length of stay for our nonsurvivors (9 days) is identical to that reported by Davis et al.<sup>13</sup> However, our survivors required intensive care for an average of 44 days and mechanical ventilation for an average of 37 days compared with 28 and 22 days respectively in their experience.<sup>13</sup> It is unclear why these differences exist. One explanation may be the existence of step-down units facilitating earlier transfer of relatively complicated patients (including those requiring mechanical ventilation) out of the intensive care unit for continued convalescence. An alternative explanation could be simply due to outliers in the data as we had several patients with very prolonged ICU and ventilator courses.

We have shown that children who develop ARDS may have improved survival compared with previous reports. Still, a mortality rate of 30% should remain unacceptable to anyone caring for critically ill children and underscores the importance of continued research and understanding of the mechanisms, treatment, and prevention of this devastating illness.

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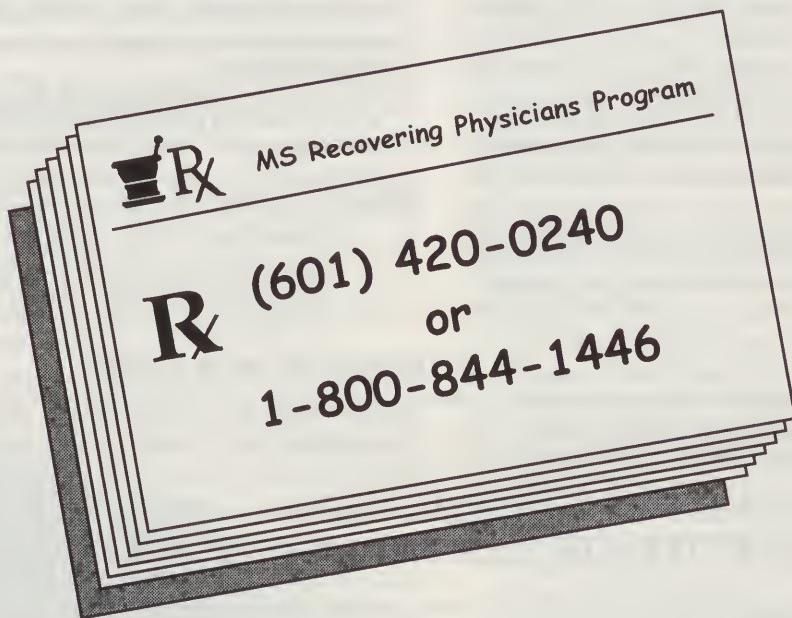
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## Recognition and Treatment of Autism: The Role of the Family Physician

Susan Hart-Hester, Ph.D.  
Sara L. Noble, Pharm D.

**E**xcessive literature exists on current theories and treatment approaches associated with autism. However, the complexity, and sometimes, inconsistencies of the spectrum of autistic behaviors make it difficult to diagnose and treat. Initial contact with the autistic individual often occurs in the office of the family physician. Distraught parents may identify a hyperactive child who withdraws from contact or a hypoactive child who clings to them inappropriately.

The purpose of this article is to assist the family physician in recognizing and treating autistic disorders through the identification of behaviors characteristic of the autistic spectrum disorder and delineation of current treatment approaches. An initial description of autism will facilitate an understanding of the complexity of this disorder.

### What is Autism?

Autism is a lifelong developmental disability that usually occurs within the first three years of life. Autism is a syndrome of behaviors that exist along a continuum from mild to severe. Such variance in severity and intensity across settings makes it nearly impossible to develop one neuro-psychological profile that is descriptive of all autistic individuals. Indeed, patients with autism differ in terms of language, cognition, and social skills.<sup>1</sup> This variability among the autistic population further complicates accurate diagnosis and treatment.

### Prevalence

Autism occurs approximately 15 times per 10,000 births or once in every 1,000 births [including Pervasive

Developmental Disorder (PDD) and Asperger's Syndrome]. Estimates show as many as 40,000 individuals diagnosed with autism in the United States. According to Mississippi statistics, nearly 4,000 individuals with autism are living in the state [(total population divided by 10,000) x 15]. Note: Because of the difficulty in diagnosis, accurate numbers are hard to predict.

While there is general consensus that autism is a genetic condition<sup>2</sup>, such recognition does not explain the higher ratio of males diagnosed autistic to autistic females (4:1).<sup>3</sup> Other disorders are also associated with autism (Mental Retardation, Fragile X Syndrome, Bipolar Disorder, and Obsessive Compulsive Disorder), which further complicates the diagnostic process.

### Causes

While it is evident that autistic individuals have neuro-psychological impairments across a number of domains<sup>1</sup>, no known cause for the disorder has been identified. Theorists have suggested a wide variety of suspected causes over the history of this disorder. Several retain a strong following: An imbalance of serotonin which adversely affects beta and alpha receptors, the administration of various antibiotics early in development which destroys natural microorganisms in the digestive tract and allows microbes such as candida albicans to develop, exposure to toxic chemicals, a leaky-gut syndrome which results from the inability to digest peptides in certain foods such as milk and wheat, and genetic conditions.

## Characteristics

Behaviors associated with autism can be categorized into four areas of dysfunction: language and communication problems, socialization problems, sensory problems, and other characteristics.

**Language and communication:** The autistic individual may have little or no speech. The acquisition of language skills may be delayed or in some cases, develop normally then regress. For autistic persons with verbal skills, the rendition of language may appear odd or inappropriate, i.e., echolalic, high pitched, sing-song, or monotone.

**Socialization:** Typically, the autistic individual does not understand social cues, including body language and facial expressions. Many may prefer to spend time alone rather than associate with a group of people, or they may prefer to play on the periphery, watching the activity but not joining in. If affectionate, such behavior is usually on his terms. He may appear to treat people like objects.

**Sensory:** The autistic person may be hyposensitive to tactile and/or auditory stimulation. Conversely, he may be hypersensitive, responding defensively to touch or sound. Such individuals lack the ability to filter the many auditory and tactile stimuli that invade the senses every minute. Some grow defensive at the sound of a distant siren or seem undisturbed by the ear splitting fire alarm overhead. Autistic persons may engage in self-injurious behavior, appearing to have a high tolerance for pain.

**Other Characteristics:** Most autistic persons experience problems in sequencing and generalizing events and skills. They may show a strong ability in one area of development but an inability in another (e.g., strong gross motor skills but affected fine motor abilities). He may evidence difficulty in discriminating important information from irrelevant information. They may experience difficulty making transitions from one activity to another, adhering to routines and ritualistic behaviors for comfort.

The following table depicts typical behaviors associated with autism:

## Diagnosis

According to criteria identified within the *Diagnostic and Statistical Manual of the American Psychiatric Association 4<sup>th</sup> ed.* (DSM-IV), autism is classified within the category of pervasive developmental disorders.<sup>4</sup> This category includes Autistic Disorder, Rett's Disorder, Childhood Integrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified. The following DSM-IV table describes specific criteria required for a diagnosis of autism.

The DSM-IV criteria along with characteristics identified in one of the autism rating scales greatly improves the accuracy of diagnosis. Several instruments are available for screening purposes: A Behavior Observation Scale<sup>5</sup>, an Autism Screening Instrument for Education Planning<sup>6</sup>, and a proposed autism checklist.<sup>7</sup> In addition, the Childhood Autism Rating Scale (CARS) offers physicians the opportunity to assess autistic characteristics using medical records, observation, parental reports, as well as data from formal testing. Information collected using the CARS can be reliably compared to data from other diagnostic systems for autism.<sup>8</sup>

## Treatment Approaches

The most successful treatment approaches begin with early identification of the autistic child. Behavioral interventions which focus on modifying specific behaviors continue to show success in the treatment of autistic individuals.<sup>9</sup> Other approaches are proving as successful and warrant further discussion: Sensory integration therapy, auditory integration therapy, psychopharmacologic treatments, and other biomedical interventions.

**Sensory Integration Therapy:** A typical characteristic of the autistic individual is his inability to filter or process sensory stimuli within the environment. This inability manifests itself through each of the senses as well as other receptive areas such as vestibular, postural stability, motor planning, proprioceptive/kinesthetic, and bilateral integration. Sensory Integration Therapy incor-

**Table 1.— Autistic behaviors**

Inappropriate laughing/giggling	Spinning objects	Socially isolated
Apparent insensitivity to pain	Lack of responsiveness to verbal cues	Inappropriate attachment to objects
No apparent fear of dangers	Sustained odd play	Echolalia
Uses gestures/points to express needs	Tantrums	Uneven development of skills- splinter skills
Little or no eye contact	Does not respond to normal teaching methods	Engages in Ritualistic behaviors
Hypo or hypersensitive	Engages in repetitive movements	Self-injurious behaviors

**Table 2: DSM-IV Diagnostic Criteria for Autistic Disorder**

<b>A.</b> A total of six (or more) items from (1), (2), (3), must have two from (1), & one each from (2) and (3).	(1) qualitative impairment in social interaction: evidenced in at least two of the following items -	(a) marked impairment in use of nonverbal behaviors, i.e., eye-to-eye contact, facial expressions, body postures, & gestures to regulate social interactions.	(b) failure to develop peer relationships appropriate to developmental level	(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)	(d) lack of social or emotional reciprocity
	(2) qualitative impairments in communication as manifested by at least one of the following:	(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)	(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others	(c) stereotyped and repetitive use of language or idiosyncratic language	(d) lack of varied, spontaneous make-believe play or social initiative play appropriate to developmental level
	(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities as manifested by at least one of the following:	(a) encompassing preoccupation with one or more stereotyped & restricted patterns of interests that is abnormal either in intensity or focus	(b) apparently inflexible adherence to specific, non-functional routines or rituals	(c) stereotyped & repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)	(d) persistent preoccupation with parts of objects
<b>B.</b> Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:	(1) social interaction	(2) language as used in social communication, or	(3) symbolic or imaginative play	<b>C.</b> Disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder	

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porates activities which involve each of these sensory receptor areas, enabling the autistic child to develop appropriate responses to his environment. For example, the autistic child may become agitated when touched by another person. Training would initiate activities which de-sensitize the child and encourage the development of appropriate responses to contact.

**Auditory Integration Therapy (AIT):** Just as sensory integration therapy desensitizes the child to environmental stimuli, auditory integration therapy utilizes the auditory tract to accomplish a similar task. This treatment helps the child develop a balance between the senses and his response to the environment. Auditory Integration Therapy is an effective treatment which can enhance social interactions and increase attention span, as well as improve gross motor and fine motor skills.

**Psychopharmacologic Treatments:** Medical interventions for autism are divided into two categories: Symptomatic treatment and neurotransmitter modulation. Symptomatic treatment is targeted to relieve or improve problem behaviors. Controlling undesirable behaviors involves many of the neurotransmitters postulated in the modulation theory. The four categories of commonly used drugs are: Dopaminergic drugs, serotonergic drugs, opiate antagonists, and noradrenergic drugs.

**Dopaminergic Drugs:** Initially, because autism was thought to be a form of childhood schizophrenia, the antipsychotic drugs or dopamine antagonists were used as pharmacological treatment. The use of haloperidol in the treatment of autistic symptoms has been clinically investigated and its effectiveness proven;

however, use of haloperidol is limited due to adverse effects such as extrapyramidal symptoms and tardive dyskinesia.<sup>10,11</sup> Symptomatic improvements in decreased stereotypies, hyperactivity, abnormal object relationships, fidgeting, and other PDD manifestations have been reported with haloperidol use in several studies.<sup>12,13,14</sup> However, efficacy with long-term use is not well-documented.<sup>15</sup> Additional antipsychotic medications have also proven to be effective, although associated with similar side effects of major movement disorders. Antipsychotic-induced abnormal movements versus abnormal movements related to typical stereotypies that occur in patients with autism is difficult to differentiate. Therefore, a baseline evaluation of abnormal movements including assessment by both the Abnormal Involuntary Movement Scale (AIMS) and the Abbreviated Dyskinesia Rating Scale (ADRS) is important.<sup>15</sup> These agents are best used in short-term therapy for autistic patients with well-structured environments at home, school, or work yet whose behavior is still disruptive. Risk versus benefit analysis should be routinely evaluated in the long-term use of antipsychotics. The atypical antipsychotic agents clozapine and risperidone may yield effective results in decreasing agitation and hyperactivity<sup>16</sup>, with fewer risks of EPS adverse effects compared to the older antipsychotic agents. Blocking serotonin receptors in addition to dopamine receptors may explain the potential efficacy of the atypical antipsychotic drugs in the treatment of autism as well as the fewer EPS-related adverse effects.<sup>17</sup> Studies indicate that between 40 to 70% of autistic individuals have hyperserotonemia.<sup>15</sup>

**Serotonergic Drugs:** Research has shown that autistic individuals have increased platelet serotonin concentrations (vs elevated whole blood serotonin levels<sup>18</sup> and antibodies formed against 5-HT neurons).<sup>19</sup> Serotonin is produced from tryptophan directly within the central nervous system (CNS). Serotonin produced peripherally is not capable of crossing the blood-brain barrier. Further, studies suggest that serotonin function affects the autistic individual's presentation of ritualistic, impulsive behaviors that appear indistinguishable from obsessive-compulsive disorder behaviors (OCD).<sup>20</sup> The application of serotonin reuptake inhibitors such as fluoxetine, fluvoxamine, buspirone, and clomipramine has proven to be effective in lessening repetitive, perseverative, and aggressive behaviors associated with the autistic individual, as well as reducing social withdrawal.<sup>21,22,23,24,25</sup> Clomipramine and buspirone are thought also to have dopamine receptor blocker activities. Antipsychotic induced adverse effects have not been reported with long-term use.

**Opiate Antagonists:** Social withdrawal, pain insensitivity, attention dysfunctions, stereotypies, emotional lability, and irritability are also seen in opiate addicts<sup>26</sup> Abnormalities in endogenous opioid levels in autistic patients have been demonstrated.<sup>27,28</sup> Generally, self-injurious behavior (SIB) occurs in 40% of the autistic population.<sup>29</sup> While the underpinning mechanisms for the development of these behaviors is not clearly understood, it has been theorized that disorders in the endogenous opiate system serve to maintain self-injurious behaviors in autistic individuals.<sup>30</sup> The use of opiate antagonists in the treatment of SIB has received varied results. Numerous reports suggested that the use of opiate antagonists such as naloxone and naltrexone were effective in the treatment of SIB<sup>29,31,32</sup>. However, other studies questioned the efficacy of their use.<sup>30,33,34</sup> The safety and efficacy with long-term administration of opiate agonists in the treatment of autistic patients is not yet known.

**Noradrenergic Drugs:** The noradrenergic system role in the etiology of PDD is important and thought to modulate arousal states. Autistic patients and their families have been found to have increased concentrations of norepinephrine.<sup>35</sup> Overactive noradrenergic systems have been substantiated from reports of cardiovascular abnormalities, higher heart rates and higher blood pressures in autistic children.<sup>36</sup> Although research has suggested the efficacy of using beta blockers to decrease aggressiveness and SIB in autistic individuals, additional controlled studies are needed. Clonidine and propranolol may have limited mediating effect on hyperactivity and irritability in autistic persons; however, further research is needed.<sup>16</sup> Common symptoms in patients with PDD include hyperactivity and inattention. Methylphenidate can reduce target symptoms of inattention, impulsivity, and overactivity in higher-functioning and adolescents with autistic disorders; however, its use may decrease hyperactivity, stereotypies may worsen, cognition can be impaired, and irritability can increase in autistic individuals.<sup>37</sup>

Since 1967, the Autism Research Institute has tracked the effectiveness of biological interventions used with autistic persons by soliciting parent ratings. Data from the Institute indicate that six drugs are typically prescribed for autistic individuals.<sup>38</sup> These medications, in their order of frequency, are 1) Ritalin, 2) Mellaryl, 3) Benadryl, 4) Dilantin, 5) Haldol, and 6) Tegretol. All of these medications showed some negative effects despite being highly prescribed by physicians. Rimland and Baker (1996) showed through parental ratings that Ritalin had an adverse effect on nearly half (47%) of the 1,971 children taking this medication.<sup>39</sup>

Overall, additional research is needed in the area of psychopharmacologic interventions associated with autism. Because of the complexity of the autism syndrome and the tremendous variance in severity and intensity of behaviors across settings, additional studies across multiple settings are required.

### Other Biomedical Interventions

Research has investigated alternative approaches to treating autistic behaviors. Antifungal agents such as nystatin, ketoconazole, and fluconazole have proven effective when the autistic disorder is yeast-related.<sup>40</sup> The lack of harmful side effects of many of the nutritional supplements used in treating autistic behaviors make them viable alternatives worth trying. Ascorbic acid (vitamin C), niacinamide, and pantothenic acid, and pyridoxine have been studied. (uncontrolled trial) The use of high dose pyridoxine (vitamin B6) and pyroxidine with magnesium, has received extensive research,<sup>38,41</sup> with mixed results.<sup>42</sup> Pyridoxine is a coenzyme for the synthesis of many neurotransmitters, including gamma-amino butyric acid (GABA). High dose pyridoxine therapy can deplete magnesium and other B-complex vitamins, with resultant sensory neuropathies. Magnesium (15mg/kg/d) and a B-complex vitamin should supplement high dose pyridoxine therapy.

Autistic individuals can experience sleep-related problems. The relationship is unclear between sleep disorders and the behavioral and cognitive manifestations of autism. There are reports of improvement in sleep patterns in developmentally delayed children at doses of 2.5 to 5 mg at bedtime.<sup>43</sup> The consequences of chronic, exogenous supplementation with melatonin are not known.

Other approaches require the removal of various food products, such as milk, wheat, or sugar. These remedies have proven effective based upon parental ratings from the Autism Research Institute data. With near zero side effects, implementation of any or all of these alternative treatments is accomplished through the efforts of the primary caregiver.

### Discussion

Early identification of the autistic individual is vital to the successful implementation of treatment options which offer the greatest opportunity for success. Generally, behavioral intervention is a necessary ingredient in the successful mix of treatment approaches for the autistic person. A combination of medical interventions and behavior intervention plans often prove the most efficacious. Understanding the complexities of the spectrum of autistic behaviors leads the family physician to initiate a team approach for the development of treatment plans which have the greatest potential for successfully ameliorating specific autistic behaviors. Recognition of the complexity of the continuum of autistic behaviors, their variance across settings, behaviors, and individuals, affords the caregiver a unique advantage point from which to plan interventions. Future research may enable the clinician to identify specific psychopharmacologic agents based upon their effect on problems in specified settings or upon a specific subgroup of autistic individuals.

In conclusion, the family physician may be the first member of a team of caregivers who focus on the initial identification of the autistic individual and the development of a proactive treatment plan. The treatment plan should address each of the dysfunctional domains - lan-

**Table 3.— Outlines a symptomatology based treatment approach for individuals with autism.**

Target behavior(s)	Drug Type	Example(s)
Aggressiveness	Beta-blockers; Dopamine-receptorblockers; Serotonin re-uptake inhibitors;  Mood stabilizers; Anxiolytics	Propranolol, Clonidine; Haloperidol; Clomipramine, Fluoxetine, Clomipramine;  Lithium, Valproate; Buspirone
Self-Injury	Dopamine-receptorblockers; Opioid antagonists; Anxiolytics	Haloperidol; Naltrexone; Buspirone
Attention Deficit/Hyperactivity (ADHD)	Stimulants	Pemoline, Ritalin, Fenfluramine, Clonidine
Stereotypy	Opioid antagonists	Naltrexone
Perservation & obsessions (OCD)	Serotonin-reuptake inhibitors; Dopamine-receptorblockers	Clomipramine, Fluoxetine, Clomipramine; Haloperidol

Adapted with permission from Gilman JT, Tuchman RF. *Autism and Associated Behavioral Disorders: Pharmacotherapeutic Intervention*. Annals of Pharmacotherapy 1995, 29:51.

guage and communication, socialization, sensory areas, and other autistic characteristics. The aspect of continuity of care for the autistic individual and his family enables the family physician an opportunity to monitor and revise treatment approaches as needed.

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# A Tribute to Felix J. Underwood, M.D.: Alton B. Cobb, M.D. Reflects on Public Health and Medicine in Mississippi

**Karen A. Evers**  
Managing Editor

*During the 131<sup>st</sup> Annual Meeting of the Mississippi State Medical Association (MSMA) House of Delegates a resolution was adopted paying tribute to Dr. Felix J. Underwood. The Board of Trustees of the MSMA formally approved making a contribution in the amount of \$4,000 for the portrait of Dr. Underwood to hang in the Mississippi Hall of Fame at the Old Capitol Building and continues this fund-raising effort in collaboration with the Mississippi Public Health Association. The estimate to commission a suitable portrait to be painted from a photograph by a local artist ranges from \$6,000 to \$20,000 depending on the artist selected from an approved list at the Mississippi Department of Archives. The Northeast Mississippi Medical Society contributed \$1,500. To date, eight individual contributions have been received totaling \$1,475. Anyone wishing to support this should make a tax deductible gift to the Mississippi Department of Archives and History, with the notation on the "for" line for the "Dr. Felix Underwood Hall of Fame Portrait Fund." Send to Ms. Donna Dye, Director, Old Capitol Museum, P. O. Box 571, Jackson, Mississippi 39205-0571. — Ed.*

**A**s we seek funds to honor the legacy and accomplished wonders of State Board of Health Executive Officer and Secretary Felix Joel Underwood, M.D., Alton B. Cobb, M.D. describes his unique record in the annals of public health. Dr. Cobb, who became state health department director more than a decade after Underwood's terms expired, paints a picture of a visionary working tirelessly under economically distressed conditions to lead an organization in a successful fight against excessive death rates from typhoid, tuberculosis, smallpox, and widespread hookworm infestation to set unprecedented public health policy.

Dr. Cobb was county health officer in Sunflower County, Mississippi when Underwood was forced to retire as state health officer by jurisdiction of a public health employees retirement law in 1958. "I had very few encounters with him," recalls Cobb, "though I remember what a gracious, soft-spoken gentleman he was. He had a reputation for fairness and concern for all. He was a kind, caring person, never discriminatory."

In fact, it has been said that Underwood's reason for entering public health work was to serve all Mississippians. He served only a limited number of years in the clinical practice of medicine in his hometown of Nettleton upon graduation from medical school at the University of Tennessee in Memphis before serving as part-time health officer of Monroe County and later becoming director of that Board in 1918.

Intensely interested in the progress of public health, Underwood immersed himself in scientific research, exemplified by his serving as a member of the Committee on Scientific Work of the Mississippi State Medical Association (MSMA) of which he was president in 1919. His proficiency in medical practice was recognized by his colleagues and he was appointed director of the Bureau of Child Hygiene and Welfare and Public Health Nursing of the Mississippi State Board of Health (MSDH) in January, 1921. "It was through Dr. Underwood's dedicated involvement, recognition of needs, ability to acquire government funding, combined with his understanding of educa-



*Former State Public Health Officer Alton B. Cobb, M.D. talks about the many ways Dr. Underwood's early work helped shape public health policy.*

tion and innovative approaches that Mississippi was able to develop such a progressive program," Cobb said. Underwood's state-centered system would later be emulated in several Southern states.

Some examples of the progressive programs Underwood developed are Occupational Health, Mental Health and Sanitation.

The program now known as occupational health began in Mississippi with the Office of State Factory Inspector. In 1929, this Division was designated as the Bureau of Industrial Hygiene (and Factory Inspection) by the Mississippi Board of Health. "I remember Dr. Huron Lovelace Vaughan was the industrial hygienist," recalls Cobb. The program began with workroom surveys in a large number of industries which included sanitary facilities, raw materials and byproducts handled, and control measures for hazardous materials (if any). They also surveyed for safety personnel, medical and nursing care, and whether or not records were kept for sickness and accidents. "Underwood was responsible for starting an extensive physical examination program for factory work-

ers during that period," said Cobb, "which included Wasserman, malaria, blood pressure, tuberculin test, and heart and throat examination."

At the May 1942 State Medical Association meeting held in Jackson, the first Industrial Health Committee of the Association was authorized and at the next annual meeting the Committee made a report as follows:

"Since the last meeting of this assembly, its Committee on Industrial Health has found a tremendous increase in need for its services.

"This has been brought about by two fundamental conditions. First, Mississippi has undergone in the past year a considerable increase in its industrialization, due, to a great extent, to the local allocation of government contracts to our manufacturers. Second, industry is rapidly becoming cognizant of the manifold advantages that can accrue to it through the intelligent utilization of safety, health and welfare services within their plant.

"Almost all industries have found they were forced to lengthen working hours, introduce additional shifts of workers, change many of their production facilities, educate an increasing number of new workers, and pay increasing care to absenteeism, labor turnovers, injuries, and safety appliances.

"This Committee has felt responsible for being able to offer detailed consultation services to aid them in meeting these critical problems.

"Therefore, in cooperation with Dr. Felix Joel Underwood of the State Board of Health, the services of the Division of Industrial Hygiene were considerably expanded by the appointment in October of a full-time physician, trained in the administration of industrial health problems; a full-time nursing consultant to aid in the development of a well oriented and organized and thoroughly controlled nursing service. This spring the service of this division has been further augmented by the full-time employment of an industrial chemist and an engineer and the building and equipping of a laboratory for affording the same accuracy for occupational diagnosis that all of us have been in the habit of expecting in hospitals for non-occupational illnesses.

"In addition to this combination of physician, nurse, chemist and engineer that is the customary type of service offered in almost all the other states, your Committee has recognized the growing importance of the frequency with which industry has made some effort to provide eating facilities for their employees by securing for this division the part-time services of the state nutritionist.

"It would be a simple problem for any of us to make outlines of Sippy or Epstein diets, but in the face of food shortages and rationing and frequently complex problems of not only what to feed, but how to acquire it, how to

preserve it, and how to serve it, specialized experience and training is required.

"Notwithstanding the fact that these additions to the staff are new, the program is showing results in Mississippi industry. Industrial hygiene services have been extended to the employers of women during the surveys of these factories as required by law; also all industries receiving government contract are now being contacted and the advantages of organized medical, safety, and welfare programs stressed in their management together with detailed consultations covering particular problems that are introduced in the individual plant by the requirements of the new contract.

"The Division of Industrial Hygiene of the State Board of Health is going into a new year with a full complement of personnel. It is hoped that the members of this Association will increasingly avail themselves of these new services to acquire precise and detailed advice on all phases of industrial health problems.

"Do you want a speaker for some group? Do you have questions on industrial toxicology or some of its legal aspects? Do you know whether the water supply in your industries is safe? Do you know how best to improve the company's eating facilities? Do you know whether and how a nursing service would be applicable to the needs of a given plant? Communicate with the Division of Industrial Hygiene.

Respectfully submitted,  
AUGUSTUS STREET, M.D., Chairman

"Another big program under Underwood, the Children's Mental Health program was then called the Child Guidance program," Cobb said. Implemented in 1943, Mississippi was one of four states to have such as an integral part of its overall program. Directed by Dr. Estelle Magiera, the original staff consisted of a psychiatrist, the Director; a psychologist, Louise Wood, B.A.M.A.; and a secretary. A year later, a psychiatric social worker became available and mobile clinics were held in Tupelo, Pascagoula, Laurel and Vicksburg.

"These clinics not only served the respective county health departments but also the surrounding communities," Cobb said. "Their primary duty was to treat emotionally upset children. After interviewing both the child and parents and studying a case, a staff conference was held, attended by school superintendents, principals, teachers, county health department personnel, welfare workers, ministers and others working with children." Cobb said.

By 1947, federal funds allowed for expansion of psychiatric services throughout the State. "Psychiatrists from Whitfield and two full-time agency psychiatrists,

Drs. Mary Alice Lee and Nina G. Moffitt provided training and consultation to local health department staffs in evaluation and treatment of patients across the state."

"One of the Dr. Underwood's greatest attributes," said Cobb, was that "he understood the importance of partnering. Beginning with staff in the county health departments, he would organize partnerships for projects with voluntary health agencies—the Heart Association, Cancer Association, March of Dimes, Red Cross, etc.—and also with other agencies, for instance the School Health program was developed in partnership with the Department of Education and the Health Education program with the Extension Service. In some instances, the State Health Department had joint staff with other agencies," Cobb said.

Perhaps it was Underwood's "partnering" concept that allowed the State Board of Health to carry on its public health work in spite of curtailed appropriations. The public health problems generated by the Mississippi River Flood of 1927, the first large-scale disaster to be faced after Underwood's appointment, were enormous. The American Red Cross and the MSDH initiated a coordinated emergency program for providing the necessary medical, nursing, and sanitary service. In the *Biennial Report to the State Board of Health, 1925-27*, Underwood estimated 60,000 people were given complete care during the refugee camp period, followed by the return to their homes with free rations and medical service during the thirty-day clean up period. Dr. Underwood wrote "... as a result of the coordinated program developed with state and federal health officials, county medical societies and local health departments, 118,818 people were completely immunized against typhoid fever, and 24,004 against smallpox. There have been no epidemics and the incidence of disease has been less than that normally expected in an ordinary group."

The emergency program also included a drive against malaria and diarrhea, and the prevention of pellagra from dietary deficiencies. The Report further states, "The Red Cross employed thirty physicians (in addition to twenty-six donating their services) and twelve health officers and sanitarians. The work of the sanitarians was tremendous for, in addition to having to reestablish and disinfect city water supplies, there were an estimated forty thousand carcasses of dead hogs, cows and mules to dispose of, plus the disposal of human waste. Mosquito control was effected by screening homes, destroying mosquitoes and the ditching, draining and oiling of stagnant pools to prevent them from breeding." Underwood wrote that this work during the 1927 flood was surely "... the greatest cooperative effort ever made in the health field between

an official group and a volunteer relief agency."

"Underwood also partnered with federal agencies like The Commonwealth Fund and the Rockefeller Foundation," said Cobb. The International Health Division of the Rockefeller Foundation had also given aid to the State Board of Health in developing full-time county health units throughout the flood area.

Following the flood, there was an epidemic of poliomyelitis in Mississippi, as in the nation, in 1936-1937, there being 138 cases reported in the state in 1936 and 385, in 1937. According to subsequent Board records, the State Board of Health and the Crippled Children's Service set up a clinic in Jackson for early adequate treatment, with follow-up clinic and field service. In the 1946 epidemic of poliomyelitis, when 312 cases were reported in the state, the polio clinic was enlarged with funds provided by the National Foundation for Infantile Paralysis, and hospitalization agreements for treatment of polio victims were made with the Vicksburg Hospital, Inc., and Mercy Hospital-Street Memorial in Vicksburg. The Salk poliomyelitis vaccine was administered first as a pilot project in Hinds, Jones, and Warren counties in 1954; and the National Foundation for Infantile Paralysis then supplied the vaccine to the State Board of Health in April, 1955, for administration to all first- and second-grade children in Mississippi. At the end of ten years of immunizations only six cases of poliomyelitis were reported in the state for a two-year period.

The changeover from the administration of the injectable to the oral poliomyelitis vaccine was made in 1965-1966. Dr. Cobb recalls sending polio patients with paralysis over to the iron lung unit at Mercy Hospital in Vicksburg when he was a county health officer. He also remembers a few "granny midwife" meetings which he described as "just as much a ritual or ceremony with a powerful spiritual feeling as it was procedure."

"Dr. Underwood's promotion of public health work in the state through organizational and basic program development paved the way for our statewide public health system," Cobb reiterated. "Sanitation- partnering with the Works Progress Administration (WPA) to construct pit privies for safe disposal of human waste was a basic health service which like other programs were developed to fit the needs for the time. They used to have traveling road shows, where a vehicle with a load speaker would take the sanitarian into a community, to get the message to the public—for hookworm control, don't walk barefoot in areas around outdoor privies" Cobb recalled.

"There were radio programs every Saturday morning," Cobb said, "on nutrition, sanitation, vaccinations, etc. There was a major emphasis on education. For

pellagra control they taught proper diets. And many of the programs that Underwood instigated are still operational today, though they have been updated to fit today's needs and approach to organization and delivery of public health services."

Dr. Underwood is also credited for the organizational system used by health departments. "He believed in a state-centered system- uniform statewide services with quality standards for all operations. He felt this offered the best use of resources and best clinics for every Mississippian to have access to quality public health services," Cobb said. "Underwood opposed authorizing local boards of health," Cobb said. There were those that thought "local boards would be dominated by a few local doctors who would limit health departments' services. They saw it as competition, Underwood felt."

"That's why our system had such a strong influence on other Southern states- Alabama, South Carolina and to a lesser extent Georgia, Florida, Louisiana and Tennessee," Cobb said.

On July 1, 1973, Alton B. Cobb, M.D. was appointed state health officer to replace Dr. Hugh B. Cottrell upon his retirement. It was Cobb, who had served as director of the Mississippi Medicaid Commission and of Comprehensive Health Planning in Mississippi, who was responsible for establishing the public health district system which coordinated preventive health services to Mississippi people from the state to the local level. Moving to the district management proved to strengthen and improve the efficiency of service delivery.

In an atmosphere where civil rights upheavals were fresh in memory and the national image of Mississippi was grim, Dr. Cobb maintained steady health progress and kept staff morale and professional performance high. Under his leadership, Mississippi pioneered integration of services at county health departments, a major departure from the traditional categorical service delivery system.

In 1992, Cobb was awarded the American Public Health Association's Award for Excellence in recognition of his "exceptionally meritorious contributions to the improvement of the health of the people. The award honors creative work of particular effectiveness in applying scientific knowledge or innovative organizational work to the betterment of community health."

Dr. Cobb led Mississippi's public health system in introducing a policy for fee collections for public health services based on the patient's ability to pay and the billing of Medicaid and other third party payment sources for services. The 1993 *Annual Report of the State Department of Health* notes that no services were curtailed



"Dr. Underwood was a king among physicians. He was Mr. Public Health." — Alton B. Cobb, M. D., MPH

because sources of funding provided support of the statewide system of preventive services despite state and federal funding cutbacks.

Other gains during Dr. Cobb's tenure include the nationally-recognized Mississippi WIC Program, reduced infant mortality and tuberculosis, modernized public health statutes, compulsory school immunizations, stronger patient protection in nursing homes and licensure regulations for home health, a statewide emergency medical services system and expansions in environmental health.

The list of awards given to Cobb in recognition of his outstanding contribution to the health and well-being of his fellow man shows the scope of his activities. The Association of State and Territorial Health Officials, of which he is a past-president, awarded him the Arthur T. McCormack Award in 1984, the same year he received the Mississippi Public Health Association's Felix J. Underwood Award. He received the Tulane University School of Public Health and Tropical Medicine's Outstanding Alumnus Award, 1982, and the Mississippi Chapter of the American Society for Public Administra-

tion, Public Administrator of the Year Award, 1981.

Cobb, called the dean of state health officers, held the post for nearly 20 years, longer than any other state's health officer, before semi-retiring in 1993. His greatest disappointment upon leaving office, said Dr. Cobb, was that he was never able to get enough money to do the job as well as it should have been done.

Dr. Cobb deserves recognition for leaving the state in far better health when he left office. He continues to serve as clinical coordinator for Information and Quality Healthcare (I.Q.H.), a quality improvement organization, and continues his crusade to have a portrait for Dr. Underwood in the Mississippi Hall of Fame.

"It will be a valuable recognition for this outstanding Mississippian; it will also be a recognition for Mississippi physicians, public health workers and all who have worked to improve the quality of life for our people thru health care," Cobb said. "We are making progress to raise sufficient funds for a quality portrait but we still need additional support to reach our fund goal," he said.

A note accompanying a recent contribution reads, "In 1932 Dr. Underwood persuaded my father to leave the Rockefeller Foundation and join the State Board of Health. My father remained with the Board of Health for forty-four years. He had great respect for Dr. Underwood and referred to him as 'Chief.' It is a pleasure to contribute to this memorial to such an outstanding man. — Clyde X. Copeland, Jr."

Indeed, it seems any contribution, regardless of size, would pay tribute to this gentleman who encouraged physicians with his high ideals and standards of excellence and whose public health groundwork serves generations from cradle to grave.

(Please complete and mail.)

**For the "Dr. Felix Underwood Hall of Fame Portrait Fund."**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE #: \_\_\_\_\_

**Make check payable to the: Mississippi Department of Archives and History.**

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P. O. Box 571  
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# The Quality of Blood Products in Mississippi Takes Another Leap Forward

Pamela L. Jett, M.D.,  
Medical Director, Mississippi Blood Services, Jackson, Mississippi

As of October 1, 1999, all red cell products manufactured by Mississippi Blood Services are leukoreduced. This change came on the heels of another major quality improvement, Nucleic Acid Amplification Testing (NAT) of all blood. With technology enhancements and improved buying power, we have been able to drop the cost of leukoreduced red blood cells (RBC) by well over 10%. This price reduction for a blood center prestorage leukoreduced RBC should make it less expensive than the cost of adding a bedside leukoreduction filter to a unit.

Generally accepted indications for the use of Leukocyte-Reduced Blood Components include:

- Preventing non-hemolytic febrile transfusion reactions
- Preventing CMV transmission by cellular blood components
- Preventing or delaying alloimmunization to leukocyte antigens in selected patients who are chronic transfusion candidates
- Delaying and/or preventing development of a platelet refractory condition
- Avoiding transfusion related immunosuppressive effects
- Preventing viral reactivation

Although bedside filtration has been shown to be effective, it has drawbacks. For example, as blood warms during transfusion, filtration becomes less efficient. And

bedside leukoreduction is a strain on nursing staff resources. Normally quality-control is only performed on products leukoreduced at a blood center. The FDA (Food and Drug Administration) permits blood products to be labeled "leukocytes reduced" if they contain less than  $5.0 \times 10^6$  WBC.

The Blood Products Advisory Committee (BPAC) of the FDA recently agreed that, from a scientific standpoint, the benefit-to-risk ratio associated with leukocyte reduction is sufficiently great to justify universal leukoreduction of all non-leukocyte cellular blood components. Mississippi Blood Services has offered leukoreduction of all blood products, at the ordering physician's discretion, for many years. Since April of 1998, all apheresis platelets have been leukoreduced at the time of collection by Mississippi Blood Services. In the Spring of 2000, when a filter allowing prestorage leukoreduction of random platelets is available, Mississippi Blood Services will implement universal leukoreduction of all non-leukocyte cellular blood components in accordance with the BPAC recommendation.

Canada and a number of European countries have implemented universal leukoreduction as well as a number of hospitals in-state and out of state, including such places as Vanderbilt University Medical Center, Nashville, Tennessee and Carraway Methodist Hospital, Birmingham, Alabama. A recently published study from Dr. James L. Newsome at Carraway showed that patients receiving leukoreduced blood have fewer complications,

hence shorter stays — therefore, recouping the cost of leukoreduction.

In discussing St. Dominic Hospital's position on the use of leukoreduced RBC's and apheresis platelets, Dr. James Almas stated, "Prestorage leukoreduced red cells as provided by Mississippi Blood Services is the highest quality product available. At St. Dominic the patient receives the best possible care, to help achieve the best possible outcome. We will proudly provide leukoreduced RBC's to our patients, recognizing the many clinical advantages such as decreased risk of infection and improved clinical outcome."

It is anticipated that all blood centers in the United States will be exclusively producing prestorage leukoreduced (non-leukocyte) cellular blood components by the end of year 2000.

*For more information, call Mississippi Blood Services Medical Director, Pamela L. Jett, M.D. at (601)981-3232. To order products, call MBS Hospital Services at (601)984-3777.*

## The 2000 International Conference on Physician Health Issues Call for Papers

The 2000 International Conference on Physician Health cosponsored by the American Medical Association and the Canadian Medical Association has issued a CALL FOR PAPERS. The meeting will be held at Seabrook Island, South Carolina on March 29 - April 2, 2000. For a copy of the Abstract Submittal Form contact: Elaine Tejcek, 312 464-5073; or e-mail: elaine\_tejcek@ama-assn.org. Deadline for submittal is October 31, 1999.

## MSMA Announces Practice Management Workshops

For your general information, MSMA will sponsor Practice Management Workshops workshop's as follows:

**Tupelo-Tuesday, January 18th, Executive Inn on Gloster**

**Jackson-Wednesday, January 19th, Primos Northgate**

**Biloxi, January 20th , Holiday Inn Coliseum**

Wanda L. Adams, CPC, will be instructor. Adams is owner and president of Adams & Associates, a health care consulting firm. She is a senior health care consultant and published author. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.

Topics have not been finalized at this time. Registration forms have been mailed. Refer questions to Debra Collins, 601-853-6733, ext. 315 or 1-800-898-0251.

**MSMA 132nd  
Annual Session  
May 19-21, 2000**



**Beau Rivage  
Biloxi, Mississippi**



**W. Briggs Hopson, Jr., M.D.  
The President's Page**

## Blessings

**I**n today's fast paced, fast moving, electronic computer based society, how often do we stop and give thanks for all the blessings we have received. Some months have certain days with special meanings. This is one of those. This month we stop to remember all the blessings we have received. Sometimes we forget those blessings and I would like to share with you the things for which I am thankful. Hopefully, you will take this list and make one for yourself, and read it to your family on November 25, the day that we as a nation stop to give thanks for all of our blessings.

First of all, I am blessed because I have a wonderful wife, great children, and six healthy intelligent grandchildren. I am blessed because I live in a country where I can express my views on politics, education, and religion without fear of reprisal. I am blessed because I live in a country where there is no socialized medicine system and where we, as physicians, have the right to practice as we see fit. I am blessed because I have a good group of clinical associates to work with, a group that has multiple diversity in practice but a common goal, that being "patient first." I am blessed because I have a caring compassionate concerned staff, in both Vicksburg and Jackson. I am blessed because I have the opportunity this year to lead the best medical association in the United States. I am blessed because the legislature decided to fund Trauma Care and the Children's Health Insurance Program, and to establish a trust fund with the monies we receive from tobacco. I am blessed because I am surrounded by approximately 4,000 other caring physicians in this state. I am blessed because God gave me the knowledge and the ability to become a physician. I am blessed because I can relieve the sufferings and help to improve the lives of my patients. Most of all, I am blessed because I know that all of these blessings came from a power on high, a supreme being, without whose help I would have nothing. Now I ask him to bless each of you as you bless those you love.

A handwritten signature in cursive ink, appearing to read "Briggs".

# Editorials

JOURNAL OF THE  
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## PATIENT PROTECTIONS

A new form of veterinary medicine spreads across the land these days. This isn't the kind represented by the wry comment a medical student learns when treating someone with brain disease that deprives that person of much of his humanity. Nor is it the actual treatment of cows, hogs, mules, et al. It is, rather, something more ominous. Think of a profit seeking managed care organization as someone who walks into a veterinarian's office carrying a sick dog. The idea of the pet owner is to cut his losses on this dog as much as he can. The dog, er... patient, has no say in the care he is to receive. The vet, us, tells the owner what he can do for the miserable animal. An inquiry is made into costs. The vet explains the various options. As he does so, the owner's mind spins with dollar signs, memories of soiled carpets and worries of future procedures and bills.

"Better put him to sleep," he says to the vet. "Not only is anything more not necessary, it's not worth it."

The effort to protect patients from this abomination is becoming a firestorm. From the beginning doctors have led the way - who of us wants to be put in the position of the hapless veterinarian? Now we have been joined by Democratic politicians, who we haven't usually thought of as aligned with our interests. The U. S. House of Representatives is poised to debate competing patient protection bills. The Norwood-Dingell bill, supported by the AMA, would allow patients to sue their health plans in state courts for medical malpractice when denied needed benefits. By declaring to doctors and hospitals which treatments are necessary and, thus, paid for, managed care organizations most certainly are practicing medicine. Incredibly, in our legal system they are exempted from being held liable for injury at the same time that McDonalds is held accountable for a customer spilling hot coffee in his lap.

Conservative Republicans, however, will have none of this logic. Their competing Coburn-Shadegg bill puts so many obstructions in the way of patient's ability to sue health plans as to make the concept useless. There are enough law suits against doctors and hospitals, they say. No more should be added against health plans. Their logic makes one want to stagger over to a whiskey bottle.

Never, however, underestimate the ability of trial lawyers to make a case. Even with the present prohibition of health plan liability for malpractice, they are about to unleash their armored divisions to blast a new legal trail, thus perhaps becoming an unlikely ally. In early October a prestigious, New York law firm filed a class action suit in federal district court in Miami against Humana. The attorneys are claiming a breach of legal duty to plan participants and a pattern of illegal activity violating federal anti-racketeering laws. Humana, it is said, allowed claims to be reviewed by persons without proper medical training and concealed from patients various incentives to encourage reviewers to deny claims. The *Wall Street Journal* is predicting other class action suits of a similar nature, fueled by fees awarded in the tobacco cases.

We are only a part of the struggle for patient protection, but a critically important part. Let us do what we can to gain passage of the Norwood-Dingell bill. And let us remember that in keeping the patient's interest first, we will prevail.

— *Leslie E. England*  
*Editor*

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

## PANT-SUITS BRIEFCASES, AND JACK-BOOTS

Donald A. Hopkins, MD, FACS  
The Breast Disease Clinic, Gulfport, Mississippi

A week ago my overworked office-manager was preparing charts and gathering mammograms for my upcoming afternoon clinic. We were expecting the usual 25 or so patients, including several new patients. Also, there were two unfortunate patients to which I would have to break the news that they had breast cancer, based on biopsies done the day before. (My practice has been strictly limited to diseases of the breast for a little over ten years. My clinic sign says so and my yellow page ad says so. All my letterheads and bills indicate that this is a clinic that treats only breast disease.)

Suddenly, two ladies carrying briefcases came into the clinic to announce rather abruptly that they were from the Mississippi Medicaid Commission and that they wanted to review patient records. Specifically, they had a list of 30 patients for which they wanted the records pulled and put in alphabetical order! My rather astonished office manager replied that the upcoming afternoon clinic was so busy that she might not have time to pull the records that day. She was informed in no uncertain terms that these "auditors" would be back the next day at 9:30 AM and expected to have the records and a place to evaluate them and microfilm them. The records were pulled and were available the next day.

These two ladies, true to their word, were at the clinic early the next morning. They spent all morning examining the records and after a lunch break came back. I finally had time to confront them personally for the first time. I asked them what was going on- "what was this audit all about?" I was told rather curtly that this was "routine." I asked that since it was so routine, how long had they been doing such spur of the moment audits. I was told "Oh, for years," I explained to them that I had been accepting Medicaid since its inception in the late 1960's, at which time I was in general practice in Crystal Springs, but had never had such an audit. They finally admitted the purpose of the examination. Their records revealed that I do a higher percentage of breast biopsies than the average general surgeon and therefore there must be some wrongdoing. I explained that my entire practice, though I am a board certified general surgeon, consisted

of problems related to the breast. Basically the only two procedures I do are some form of breast biopsy or some form of operation for breast cancer, I explained that a phone call from Jackson could have resolved their question in a few seconds if they were unclear as to why all my bills to Medicaid were payable to "*Mississippi Breast Disease Clinic*," These ladies were unimpressed by my logic. I was informed that when I signed to participate in Medicaid I consented to an audit at any time. True, but I naturally assumed that this type of abrupt intrusion would happen only in cases where fraud or other criminal activity was strongly suspected. Evidently this tactic of suddenly dropping in on a busy clinic and making demands is standard or "routine," even when there is no real suggestion or evidence of wrongdoing.

A courtesy phone call or letter from some functionary at the state Medicaid Commission notifying me of the questions about the number of breast biopsies, or an attempt to schedule this "routine" audit when convenient with my office manager and me, would have been appropriate.

Now, I know these ladies were just doing their job. I also know that we taxpayers were paying their salaries for doing their job. Their abrupt arrival at my clinic coupled with their demands reminded me of the old W.W.II newsclips showing jackbooted\* bullies pushing around helpless and law-abiding citizens at the behest of the State. Obviously these ladies did not wear jackboots- their tactics simply brought this to mind. Their visit did resolve a lingering problem for me. As I explained to them, their heavy-handed actions were the final straw. For over 33 years I have felt that all physicians privileged to practice in Mississippi owed it to the poor to take care of at least some Medicaid patients. This attitude changed on 15 September. I no longer feel any sort of responsibility to accept Medicaid as insurance coverage. My new attitude is due to the many problems associated with Medicaid - all well known to my colleagues, plus this most recent intrusion into my practice.

\*Jackboots: Heavy leather boots often associated with the Nazi Gestapo and other thugs.

The comments expressed in this Journal are those of the indicated author. Comments and opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit comments for publication regarding any opinion expressed or information contained in the Journal.

## Quality Indicators

In 1994, the Health Care Quality Improvement Program (HCQIP) was begun as a health care quality measurement and improvement program. The program is based on the Continuous Quality Improvement model which is widely used in business and industry.

Under HCQIP, Peer Review Organizations have become Quality Improvement (QI) entities.

The methodology is to collaborate with hospitals and more recently with clinics and other care delivery systems in projects to measure and improve process-related quality indicators that have been shown to be positively related to improved patient outcomes. The indicators used are mainly selected from clinical guidelines. Guidelines based on clinical trials are preferred for their being evidence-based. In effect, these projects integrate and apply clinical guidelines to local practice in a cooperative educational environment.

I.Q.H., after a four-month extension period between the Fifth and the Sixth Scope of Work, has begun its Sixth Scope program. Emphasis is being placed on the following national health improvement clinical areas to significantly impact the state's Medicare population.

**Acute Myocardial Infarction:** Quality indicators include early administration of aspirin, aspirin at discharge, early administration of Betablockers, Betablockers at discharge, ACE inhibitor for low LVEF, time to initial reperfusion, and documentation of smoking cessation counseling provided during hospitalization.

**Heart Failure:** Quality indicators are the assessment of LVEF and appropriate use of ACE inhibitors for patients with low LVEFs.

**Pneumonia:** Quality indicators are time to initial antibiotic administration, initial antibiotic selection, influenza and pneumococcal (PPV) immunization assess-

ment and immunization for non-immunized individuals.

**Stroke/Transient Ischemic Attack/Atrial Fibrillation:** Quality indicators are aspirin/antiplatelet/warfarin for stroke and TIA, warfarin for atrial fibrillation, and reduction of inappropriate use of sublingual nifedipine following acute ischemic stroke.

**Diabetes:** Quality indicators are biennial retinal exam by eye professionals, annual HbA1c testing, appropriate assessment for nephropathy, and biennial lipid profiles.

**Breast Cancer:** Quality indicator is biennial screening mammography with clinical breast exam. In the past, I.Q.H. has participated in promoting the importance of mammography; this Scope of Work represents the first official HCQI project utilizing data to obtain measurable improvement in mammography rates.

Each QI organization will be evaluated based on statewide improvements for each of the quality indicators. In the past, evaluation was determined by rate of improvement for project indicators in collaborating hospitals.

Data available show that for most of the indicators significant opportunities remain for improvement in Mississippi. As a result of past projects, some of the indicators are up, notably the use of warfarin in atrial fibrillation; shorter time interval between AMI admission and reperfusion; and improvement in the influenza immunization rates.

In order to improve on these important care processes that significantly improve patient outcomes, we need the involvement of all hospitals, physicians and other care givers to move our Mississippi rates in alignment with nationally accepted evidence-based guidelines.

—Alton B. Cobb, M.D.  
*Clinical Coordinator*



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## New Members

**Alexis, Katherine Pigott**, Pascagoula. Born McComb, MS, January 2, 1970; MD University of Mississippi School of Medicine, Jackson, MS, 1996; family medicine residency, University Medical Center, Jackson, MS, 1996-1999; elected by Singing River Medical Society.

**Alloju, Murali M.**, Greenville, MS. Born India, March 15, 1958; MBBS Kakativa Medical College, India, 1982; internal medicine residency, Toledo, Ohio, 1993-96; gastroenterology fellowship, Detroit, MI, 1996-99; elected by Delta Medical Society.

**Amann, Stephen T.**, Tupelo. Born Niagara Falls, NY, September 8, 1963; MDCreighton University School of Medicine, Gainesville, FL, 1989; internal medicine residency, University of Florida Medical Center, Gainesville, FL, 1989-92; gastroenterology fellowship, same, 1992-96; elected by Northeast MS Medical Society.

**Bell, Williams J.**, Saltillo. Born Hinds Co. MS, December 20, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1995; family medicine residency, University of Mississippi Medical Center, Jackson, MS, 1996-98; elected by Northeast Medical Society.

**Bibi, Zouhair**, Tupelo. Born January 1, 1956; MD University of Medicine, Tubingen West Germany, 1985; internal medicine residency, 1992-94; endocrinology fellowship, Baylor College of Medicine, Dallas, TX, 1989-91; elected by Northeast Medical Society.

**Birdwell, Amy J.**, Jackson. Born Haynesville, LA, July 12, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1996; family medicine residency, University Medical Center, Jackson, MS, 1996-99; elected by Central Medical Society.

**Booth, David G.**, Eupora. Born Louisville, MS, October 24, 1961; MD Southeastern College of Osteopathic Medicine, Miami, FL, 1992; family practice residency, University of Alabama Medicine Center, Birmingham, AL, 1992-95; elected by Northeast MS Medical Society.

**Borman, Karen R.**, Jackson. Born Washington, DC, December 1, 1953; MD Tulane University School of Medicine, New Orleans, LA, 1978; general surgery residency, University of Texas Southwestern Affiliated Hospital, Dallas, TX 1978-84; elected by Central Medical Society.

**Brooks, David J.**, Tupelo. Born London, Ontario, Canada, October 11, 1953; MD University of Calgary, Canada, 1984; family practice residency, Holy Cross Hospital, 1985-86; elected by Northeast MS Medical Society.

**Capel, Winston T.**, Jackson. Born Salt Lake City, UT, May 13, 1963; MD Chicago Medical School, Chicago, IL, 1991; neurosurgery residency, University Medical Center, Jackson, MS, 1991-97; orthopedic spine surgery, fellowship, University of Maryland, Baltimore, MD, 1997-98; elected by Central Medical Society.

**Chandler, Berry M.**, Greenville.

Born Baton Rouge, LA, September 1, 1958; MD Louisiana State University School of Medicine, Shreveport, LA, 1984; transitional internship, Monroe, LA, 1984-85; general surgery residency, University of Florida Medical Center, Jacksonville, FL, 1985-86; elected by Delta Medical Society.

**Chiou, Andrew S.**, Greenwood. Born Taiwan, April 18, 1969; MD Albany Medical College of Union University, Albany, NY 1993; neurosurgery residency 1993-99; elected by Delta Medical Society.

**Cole, Cris W.**, Pascagoula. Born Birmingham, AL, October, 26, 1967; MD University of South Alabama School of Medicine, Mobile, AL, 1995; pediatric residency, University of South Alabama Medical Center, Mobile, AL, 1996-98; elected by Singing River Medical Society.

**Collum, Billy T.**, Fulton. Born Itawamba, MS, December 23, 1929; MD Harvard Medical School, Boston, MA, 1954; elected by Northeast MS Medical Society.

**Corkern, Mary S.**, Hattiesburg. Born San Antonio, TX, January 14, 1961; MD University of Mississippi School of Medicine, Jackson, MS 1995; interned one year Louisiana State University, EKL Hospital, Baton Rouge, LA; internal medicine residency, same, 1996-99; elected by South MS Medical Society.

**Dean, David A.**, Jackson. Born Japan October 5, 1966; DO University of Health Sciences, College of Osteopathic Medicine, Kansas City, Missouri 1992; interned one

year Brooke Army Medical Center, Fort Sam Houston, TX; one year family practice residency Dwight D. Eisenhower, Fort Gordon, GA, 1992-93; elected by Central Medical Society.

**Daniels, Anthony E.**, Columbus. Born Natchez, MS September 21, 1954; MD University of Mississippi School of Medicine, Jackson, MS, 1983; interned and ob/gyn residency, University Medical Society, Jackson, MS, 1983-87; elected by Prairie Medical Society.

**Fisher, Kevin A.**, Hattiesburg. Born San Francisco, CA, March 28, 1954; MD Creighton University School of Medicine, Omaha, NE 1981; radiology residency, University of California, San Francisco & St. Mary's Hospital & Medical Center, San Francisco, CA, 1982-84; elected by South MS Medical Society.

**Gebhart, Leland D.**, Jackson. Born San Antonio, TX June 14, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; ob/gyn residency, University Medical Center, Jackson, MS, 1996-99; elected by Central Medical Society.

**Greenwald, Alan J.**, Amory. Born Cleveland, OH, September 27, 1938; MD University of Cincinnati Medical School, Cincinnati, OH, 1964; internal medicine residency 1964-65 Mt Sinai, Clove, ON; Cedars-Sinai, Los Angeles, CA, 1967-68, University of Texas, San Antonio, TX, 1969-70; fellowship Psychosomatic Medicine, 1968-69, Cedars-Sinai, Los Angeles, CA; gastroenterology fellowship, University of Iowa Medical Center, Iowa City, IA, 1970-72; elected by

Northeast MS Medical Society.

**Haigh, Linda S.**, Tupelo. Born San Diego, CA, September 14, 1954; MD Harvard Medical School, Boston, MA, 1988; surgery residency Brigham & Womens Hospital Hospital, Boston, MA 1989-1994; elected by Northeast MS Medical Society.

**Hailey, Larry S.**, Meridian. Born Greenwood, MS, September 6, 1968; DO University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1996; internal medicine residency, Baptist Health Systems, Birmingham, AL, 1996-99; elected by East MS Medical Society.

**Hem, Halvor W., IV**, Pass Christian. Born New Orleans, LA, January 21, 1964; MD University of North Carolina School of Medicine, Chapel Hill, NC, 1994; internal medicine residency, LSU Medical Center, Shreveport, LA, 1994-98; elected by Coast Counties Medical Society.

**Henderson, Adelaide F.**, Columbus. Born Bridgeport, Conn., February 1, 1966; MD American University of Caribbean, 1991; family practice residency St. Johns Hospital, Detroit, MI, 1991-94; elected by Prairie Medical Society.

**Henderson, William E.**, Oxford. Born Oxford, MS, June 7, 1969. MD University of Mississippi School of Medicine, Jackson, MS, 1995; ob/gyn residency, University Medical Center, Jackson, MS, 1995-99; elected by North MS Medical Society.

**Johnston, Susan E.**, Starkville. Born Monroe Co, MS, September 19, 1968; MD University of Mis-

sissippi School of Medicine, Jackson, MS 1996; interned and pediatric residency, University Medical Center, Jackson, MS, 1996-99; elected by Prairie Medical Society.

**Kerut, Timothy P.**, Vicksburg. Born Huntington, NY, August 8, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1985; pediatric residency, University Medical Center, Jackson, MS, 1986-88; allergy/clinical immunology fellowship, Thomas Jefferson University, Philadelphia, PA 1988-90; elected by West MS Medical Society.

**Lineaweaver, William C.**, Jackson. Born Nyack, NY, December 19, 1949; MD University of Florida School of Medicine, Gainesville, FL, 1976; interned one year, University of Virginia, Charlottesville, Virginia, 1976-77; surgery residency, University of Florida, Gainesville, FL, 1979-83; surgery residency, University of California, San Francisco, CA, 1984-86; hand surgery fellowship, Davies Medical Center, San Francisco, CA, 1986-87; elected by Central Medical Society.

**Madden, Michael C.**, Biloxi. Born Seattle, WA, June 29, 1962; MD University of Alabama School of Medicine, Birmingham, AL, 1994; interned one year, University of Alabama Medical Center, Birmingham, AL, 1995-96; family medicine residency, University Medical Center, Jackson, MS, 1996-99; elected by Coast Counties Medical Society.

**May, Fredrick A.**, Jackson. Born South Bend, IN, January 18, 1952; MD Indiana University School of Medicine, Indianapolis, IN, 1977;

pediatric residency J. W. Riley Hospital for Children, Indianapolis, IN, 1977-80 & Medical College of Wisconsin, Milwaukee, WI, 1985-87; Medical Director of Blue Cross & Blue Shield elected by Central Medical Society.

**Moczygembba, Max J.**, Jackson. Born October 12, 1940; MD University of Graz, Graz Austria, 1980; internal medicine residency, Mt. Vernon Hospital, New York, NY, 1991-93; elected by Central Medical Society.

**Montgomery, L Lee**, Fulton. Born Lee MS, January 26, 1970; MD Vanderbilt University School of Medicine, Nashville, TN, 1996; family practice residency, Florida Hospital, 1996-99; elected by Northeast MS Medical Society.

**Patterson-Marsh, Kirsten J.**, Tupelo. Born Shelby, TN, December 24, 1963; MD University of Tennessee School of Medicine, Memphis, TN, 1996; family practice residency, University of Tennessee Medical Center, Nashville, TN, 1996-99; elected by Northeast MS Medical Society.

**Rayford, Richard**, Jackson. Born Byhalia, MS, February 1, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, University of Tennessee Medical Center, Memphis, TN, 1991-94; cardiology fellowship, University of Arkansas Medical Center, Little Rock, AR, 1995-98; elected by Central Medical Society.

**Renfroe, Doyle L.**, Jackson. Born Meridian, MS, October 10, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1993; urology residency, Univer-

sity Medical Center, Jackson, MS, 1993-99; elected by Central Medical Society.

**Schaffer, Frederick M.**, Greenville. Born New York City, NY, March 14, 1950; MD State University of New York, Buffalo, NY 1981; pediatric residency, Einstein University Medical Center, Bronx, NY, 1981-84; allergy/immunology/rheumatology, fellowship, Hospital for Sick Children, University of Toronto, Canada, 1984-86; fellowship in immunology, University of Alabama Medical Center, Div. Developmental & Clinical Immunology, Birmingham, AL, 1988-91.

**Senf, William L.**, Laurel. Born St. Louis, MO, June 16, 1966; MD University of Missouri School of Medicine, Columbia, MO, 1993; surgery residency, University Hospital, Columbia, MO, 1992-95; urology residency, Akron General Medical Center, Akron, OH, 1995-99; elected by South MS Medical Society.

**Shepard, Felix E.**, Gulfport. Born Newport News, VA, April 22, 1960; MD New York Medical College, Valhalla, NY, 1993; general surgery residency, Medical College Medical Center, Richmond, VA., 1994-95; urology residency, Same, 1995-98; elected by Coast Counties Medical Society.

**Shepherd, Kimbel D.**, Tupelo. Born Louisville, MS, September 23, 1970; MD University of Mississippi School of Medicine, Jackson, MS, 1996; pediatric residency, University Medical Center, Jackson, MS, 1996-99; elected by Northeast Medical Society.

**Stone, James E., Jr.**, Tupelo. Born

Tupelo, MS, April 26, 1966; MD University of Alabama School of Medicine, Birmingham, AL, 1992; interned and internal medicine residency, University of Alabama Medical Center, Birmingham, AL, 1992-95; cardiology fellowship North Carolina Baptist Hospital & Wake Forest Medical Center, Winston-Salem, NC, 1995-98; electrophysiology fellowship, Same, 1998-99; elected by Northeast MS Medical Soicity.

**Thomas, Jackson S.**, Jackson. Born Houston, TX, April 10, 1969; MD University of Arkansas Medical School, Little Rock, AR 1996; pediatric residency, University Medical Center, Jackson, MS, 1996-99; elected by Central Medical Society.

**Thomas, Lynn C.**, Tupelo. Born El Dorado, AR, June 2, 1950; MD University of Arkansas School of Medicine, Little Rock, AR, 1995; psychiatry residency, University of Arkansas Medical Center, Little Rock, AR, 1996-99; elected by Northeast MS Medical Society.

**Warren-Ellis, Kimberley D.**, Ridgeland. Born Houston, TX, November 26, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1996; family practice residency, University Medical Center, Jackson, MS, 1996-99; elected by Central Medical Society.

**Weisbord, Tim**, Fulton. Born Montreal, Quebec, Canada, November 29, 1944; MD McGill University of Medicine, Canada, 1969; rotating internship and family practice residency, Royal Victoria Hospital, Montreal, Canada, 1969-72; elected by Northeast MS Medical Society.

**Williams, Roger A.**, Tupelo. Born New Orleans, LA, June 15, 1967; MD Louisiana State University School of Medicine, New Orleans, LA, 1993; interned and family practice residency, University of Florida Medical Center, Gainesville, FL, 1993-96; cardiology fellowship, Same, 1996-99; elected by Northeast MS Medical Society.

## PERSONALS

**David L. Dugger, M.D.**, has moved to newly renovated offices at The Children's Clinic of Gautier. Formerly the Dugger Pediatric Clinic, The Jackson County Medical Foundation clinic announces the new name and relocation to 1408 Highway 90, Suite 1, Gautier, 39553, telephone: 497-5434.

**Maria C. Soriano, M.D.** joined Hattiesburg Clinic in the practice of family and pediatric medicine. Dr. Soriano's office is located at 2013 North Pine Street, Heidelberg. She has practiced in Heidelberg for four years before joining Hattiesburg Clinic. Dr. Soriano received her medical degree from the University of the Philippines College of Medicine. She completed a rotating internship at Philippine General Hospital Medical Center. She also completed an Internal Medicine internship and a pediatric internship and residency at Long Island College Hospital in Brooklyn, New York. In addition, Dr. Soriano concluded a one-year fellowship at Pediatric Emergency Medicine at Long Island College.

**Milton Concannon, M.D., Alan Covin, M.D. and Frank Lauro, M.D.**; Board Certified Cardiology Specialists, are pleased to an-

nounce their new practice association, The Heart Group of South Mississippi, for the practice of preventive, diagnostic and interventional cardiology.

**John M. Guice, M.D.** has opened Urological Associates of South MS, P.C., a single-specialty urology clinic dedicated to the diagnosis and treatment of urological disorders in adults and children. The clinic is located at 109 Millsaps, Suite B, Hattiesburg, 39402 (Wesley Medical Center Campus on Hwy 98 West).

**John C. Clay, M.D. and Dwight S. Keady, Jr., M.D.** announce the formation of Meridian Oncology Associates, P.L.L.C. and the relocation of their medical practices to 1200 16th Avenue, Meridian, 39301, in order to more effectively serve the special needs of their patients.

**Jewell J. Breeland, Jr., M.D.** has retired from the practice of medicine.

**John Thomas Mazzeo, MD, FACS**, of Vicksburg, MS, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Parkview Regional Medical Center. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Dr. Mazzeo is among a national network of over 1,900 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities. Dr. Mazzeo, who has a significant in-

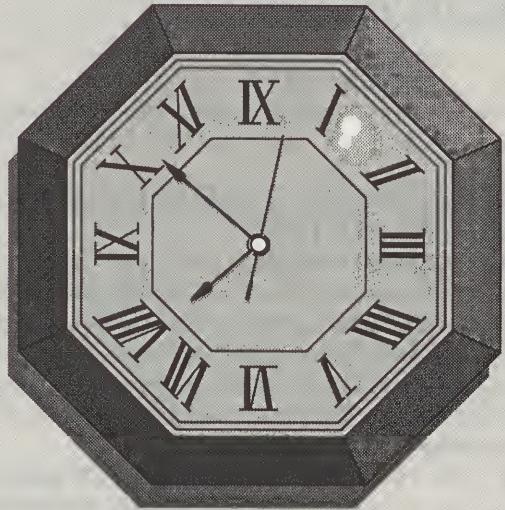
## Personals

terest in the diagnosis and treatment of patients with malignant diseases, provides leadership to the cancer committee at his/her appointed institution(s) in order to maintain their Commission-approved cancer program, or assist them in seeking approval as a new program. Dr. Mazzeo also provides community leadership by volunteering at the division or unit level of the American Cancer Society.

**Karen R. Borman, M.D.**, of Aberdeen, Maryland., was named associate professor of surgery to lead the Department of Surgery's endocrine surgery program. She also spearheads the development of the department's medical informatics office. A native of Washington D.C., her work in that office concerns surgeon reimbursement, health care policies, electronic medical records, government medical program compliance and faculty practice plan management. Dr. Borman received her bachelor of science degree in chemistry with high honors in 1974 from Georgia Institute of Technology in Atlanta and her medical degree in 1978 from Tulane School of Medicine in New Orleans. She completed her internship and general surgery residency in 1984 at the University of Texas Southwestern Affiliated Hospitals in Dallas and won the Region VII first prize in the American College of Surgeons trauma essay contest. In addition to general surgery, Dr. Borman's clinical expertise includes endocrine surgery and critical care. She also has experience in medical encounter coding and physician practice compliance.

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#### **Life and Disability 601-982-3000**

#### **Insurance 800-898-0954**

Several insurance plans specifically tailored for MSMA members are available through the association's endorsed agency, the Executive Planning Group. These plans offer low-cost group rates that may also be tax deductible.

#### **Retirement Planning 601-982-3000**

#### **800-898-0954**

The Executive Planning Group assists MSMA members in properly planning for their retirement through a variety of sound growth and tax reduction strategies.

#### **Tax Audit Defense 800-922-8348**

For a low monthly cost, MSMA members can purchase pre-funded assistance from tax experts in the event of an audit. TaxResources, Inc. utilizes former IRS agents to represent you in the event you are audited or questioned about your tax return.

#### **Mississippi Impaired 601-420-0240**

#### **Physicians Committee 800-844-1446**

Confidential assistance and support is available for physicians experiencing emotional or mental distress and/or chemical impairment/dependency. The association's Impaired Physicians Committee also operates the Mississippi Recovering Physicians Program.

### PRACTICE SERVICES

#### **Office Supplies 800-772-4346**

MSMA members can save up to 40% on medical office supplies through AMA Purchase Link. Discounted medical, surgical and pharmaceutical products are available from the largest nationwide distributor of such products to physicians' offices.

#### **Third Party Payor**

#### **Advocacy 601-853-6733**

#### **800-898-0251**

The association's Third Party Relations Task Force meets bi-monthly with representatives of health insurers and health plans in Mississippi in an effort to resolve problems that members may be experiencing with payment, coverage and other issues. MSMA members are encouraged to submit any such problems to the Task Force for resolution.

#### **Practice Management 601-853-6733**

#### **and Related Services 800-898-0251**

MSMA members have access at a reasonable price to a broad array of experts in various medical practice-related areas, such as contract review and negotiations, regulatory compliance, CPT coding evaluation, billing and accounts receivable, practice valuation, acquisitions and mergers, employment contracts, market studies and many others.

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#### **Medical Liability**

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Medical Assurance Company of Mississippi (MACM) was organized by the association in 1976 to provide a stable market for professional liability insurance. MACM is now the largest underwriter of medical liability insurance for physicians in Mississippi and it continues to be sponsored and endorsed by the association.

#### **Workers Compensation**

#### **601-853-6733**

#### **Insurance 800-898-0251**

The Mississippi Physicians Insurance Company (MPIC) was organized by the association in 1991 to provide a low-cost, alternative market for physician practices that are required to carry workers comp insurance. MPIC specializes in covering medical clinics and other health care entities.

#### **Preferred Provider**

#### **601-605-4756**

#### **Organization 800-931-8533**

The Mississippi Physicians Care Network (MPCN) was organized by the association in 1993 to provide a physician-directed managed care network for employers and insurance companies in Mississippi. It is now the largest provider network operating in the state. The annual membership fee is waived for members of the association.

## **Magazine Subscriptions 516-676-4300**

Low-cost group magazine subscription rates are available for you and your office through the association's arrangement with Subscription Services, Inc.

## **Radiation Technician Training Workshops 601-853-6733 800-898-0251**

Sponsored by MSMA, these 12 hour workshops have been approved by the Radiation Advisory Council of the MS State Department of Health. These courses will satisfy the requirements of the law passed by the Mississippi Legislature.

## **INFORMATION AND EDUCATION SERVICES**

### **The Journal MSMA 601-853-6733 800-898-0251**

Every MSMA member receives a subscription to the association's monthly scientific journal. The *Journal, MSMA* contains substantive scientific and medical practice articles, columns and medical news.

### **The MSMA Report 601-853-6733 800-898-0251**

The association's newsletter is published monthly and contains information on current medical events and association activities that are important to the medical profession.

### **The MSMA Legislative Report 601-853-6733 800-898-0251**

Published weekly during each annual session of the Mississippi Legislature, this informative newsletter provides association members with the latest news on legislative and political events. It also keeps members abreast of health legislation that is under consideration and the association's position on hundreds of health-related bills.

### **Legal Information 601-853-6733 800-898-0251**

Although the association does not provide individual legal representation for members, it will provide general legal information and opinions on Mississippi and federal laws, regulations and court decisions.

### **Membership Directory 601-853-6733 800-898-0251**

MSMA members receive a Membership Director which is published annually and includes the practice address, telephone number, e-mail address and specialty of each MSMA member by county.

### **Legislative Forum 601-853-6733 800-898-0251**

Each January the association conducts a forum in Jackson on current socioeconomic and legislative topics in conjunction with the Mississippi Hospital Association. The forum concludes with a reception honoring members of the Mississippi Legislature and other state elected officials.

## **Annual Meeting**

**800-898-0251**

The association's Annual Session includes meetings of the policy-making House of Delegates, plus a variety of other specialty, educational and business meetings and social events. It also includes an all day long plenary session where CME credit is available for attendees.

## **MSMA Website 601-853-6733 800-898-0251**

The association's website at provides a multitude of information and services for MSMA members and the general public. A special "members only" page provides specialized services, including links to other health-related and physician sites.

## **OPPORTUNITIES FOR INVOLVEMENT**

### **Women Physicians Caucus 601-853-6733 800-898-0251**

Female members of the association meet periodically to discuss their mutual concerns and work on a number of initiatives that target women. Members of the caucus also hold an annual breakfast meeting with female members of the Mississippi Legislature.

### **Young Physicians Section 601-853-6733 800-898-0251**

MSMA members under age 40 or who have been in practice less than five years can participate with their colleagues in addressing some of the unique problems affecting physicians as they begin practice.

### **House of Delegates 601-853-6733 800-898-0251**

Each recognized component society of the association is represented in the House of Delegates, which is the official policy-making body for MSMA. The House of Delegates, which meets each year during the association's Annual Session, affords physicians the opportunity to participate with their colleagues in determining how medicine approaches various health care issues in Mississippi.

### **Councils and Committees 601-853-6733 800-898-0251**

The association has a number of standing committees that deal with specific areas affecting health and medical care, from legislation to education. Council and committee seats are filled through either election by the House of Delegates or appointment by the MSMA President or Board of Trustees. Interested members are encouraged to submit their names for nomination or appointment.

### **Legislative Advocacy and Representation 601-853-6733 800-898-0251**

The association has a full-time staff that works on legislative and regulatory matters affecting physicians and their patients. These representational efforts are one of the most valuable services an association can provide, but to be effective they require the members' support and involvement. You can help by getting to know your state and local elected officials and contacting them when requested by MSMA.

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# JOURNAL

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Childhood Fever Education in a Military Population: Is Education Enough?

Obstetrical Outcome in the Very Young Adolescent

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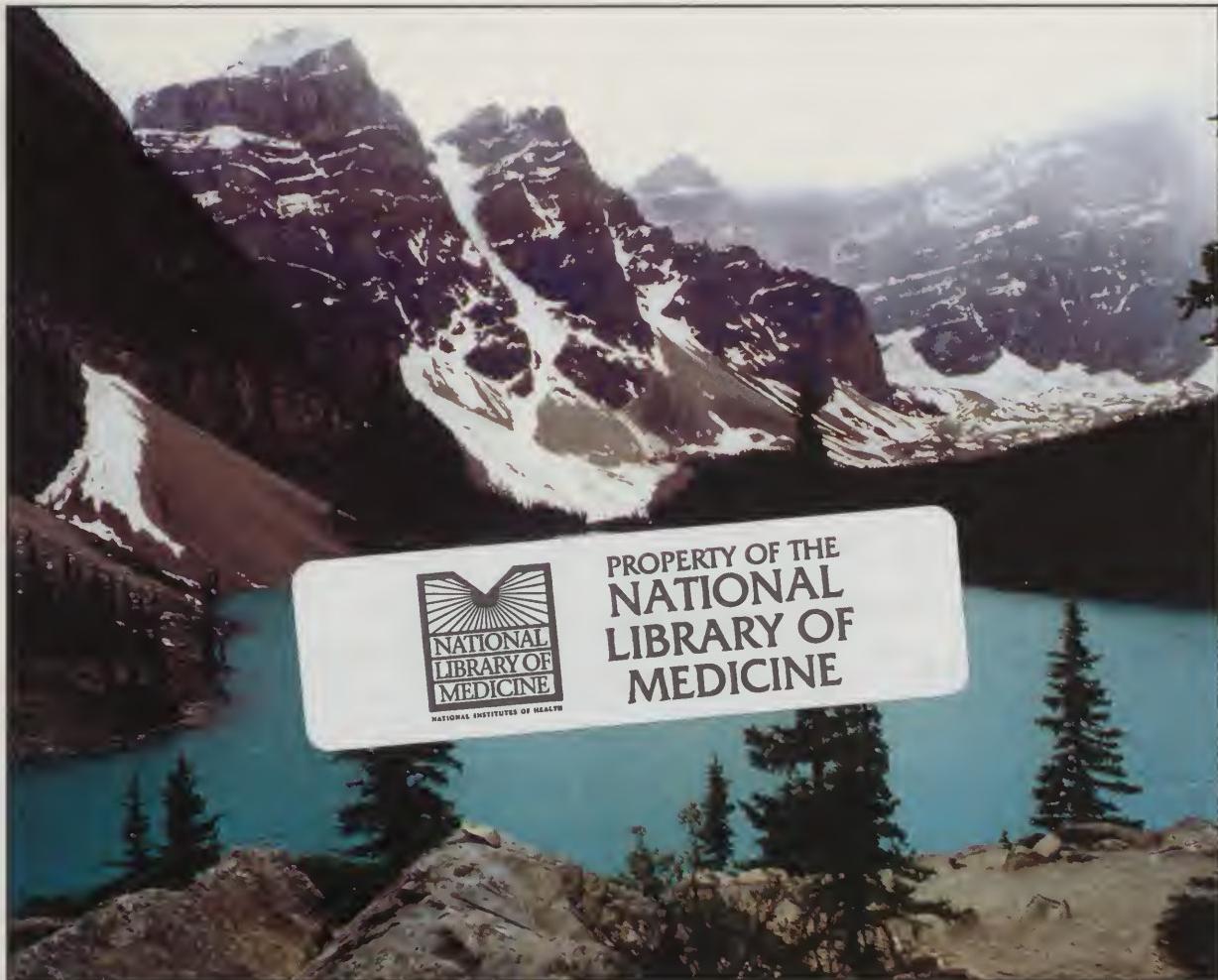
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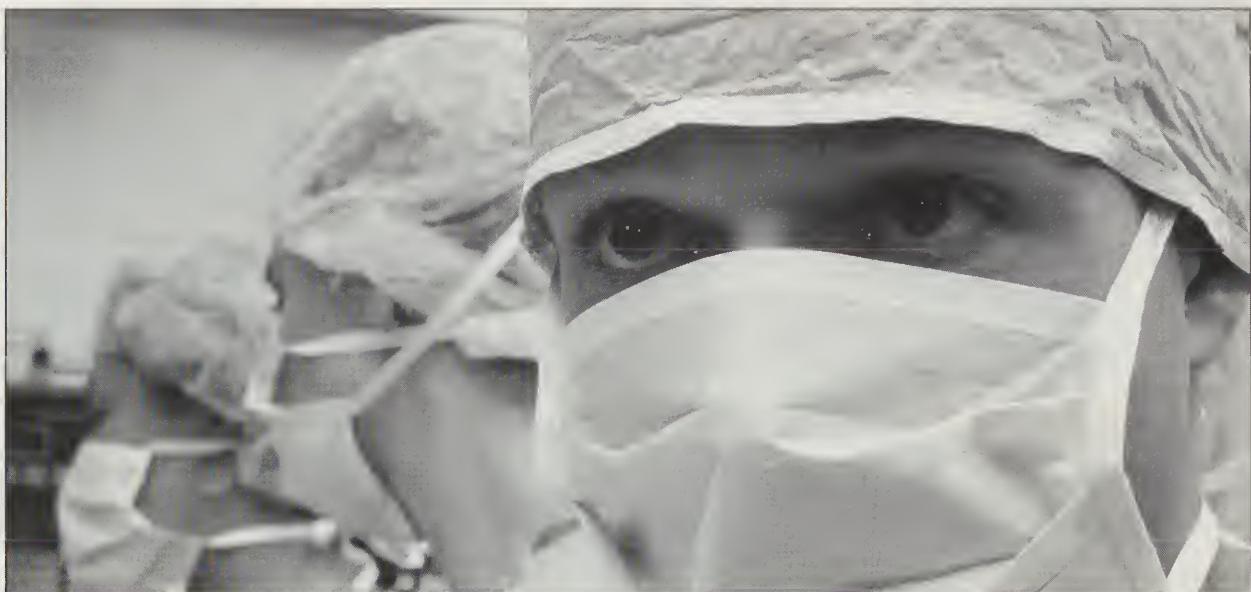
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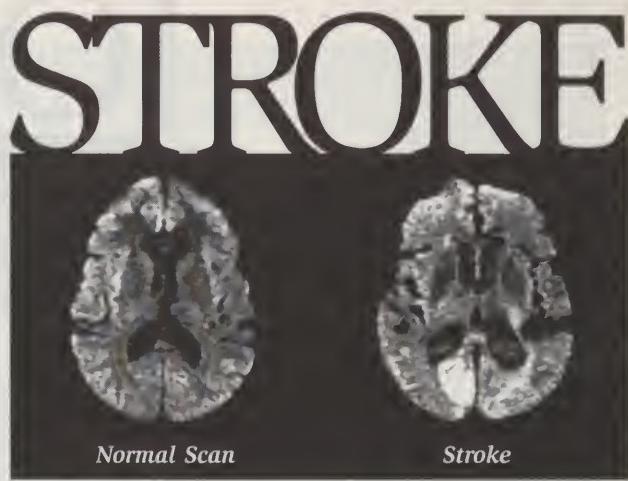
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# **Childhood Fever Education in a Military Population: Is Education Enough?**

**Joel Steelman, M.D.**  
**George S. Kotchmar, Jr., M.D.**  
**Mr. Walter T. Brehm, M.S.**  
**Kurt Greenwall, M.D.**

## **A**BSTRACT

### **Purpose**

Parental knowledge of childhood fever and clinic and emergency room utilization were studied in a military pediatric clinic population to determine if intervention would improve parental understanding and management of childhood fever.

### **Methods**

Multiple choice tests evaluating childhood fever knowledge were given to control and intervention groups. Clinic and emergency room utilization were tracked for appropriateness of visits based on criteria used in previous similar studies.

### **Results**

Initial test scores showed no difference between the two groups. Subsequent test scores revealed a difference between the two groups as reflected by improved test scores. Evaluation of clinic and emergency room utilization of the groups did not show an overall improvement except in one subgroup analyzed.

### **Conclusion**

Intervention improved parental knowledge; however, intervention did not translate into anticipated improvement in clinic and emergency room utilization patterns. Emphasis on education and preventative services are important in both civilian and military pediatric practice. Results of this study highlight the need to discuss and reinforce fever education as a topic in pediatric preventive health care visits.

**Keywords:** Patient Education, Health Insurance

### **Background**

One of the goals of pediatrics is to provide education to parents regarding care of their children.<sup>1</sup> Fever in children represents an area in which there are many misconceptions both on the part of physicians<sup>2,3</sup> and parents.<sup>4,5,6,7,8,9</sup> Efforts to educate parents regarding fever and its treatment have been performed in the past.<sup>4,8</sup> Studies by Casey et al<sup>4</sup> and Robinson et al<sup>8</sup>, respectfully, utilized an initial teaching intervention followed by a period of reinforcement. Both studies found improvement in the intervention group compared to the control group in test scores and clinic utilization patterns.

Fever surveys and interventions have been performed in multiple clinical settings<sup>3,4,5,8,9</sup>; however, none has been done in a military pediatric clinic population. The military population is different from its civilian counterparts in a number of ways including an ease of access to no fee for service medical care and a highly mobile nature with frequent moves. Three hypotheses were made at the beginning of this study. First, there are parental misconceptions regarding fever in children. Second, educational intervention will improve parental knowledge regarding fever in children. Third, the improvement of parental knowledge will decrease inappropriate clinic and emergency room visits related to fever.

### **Methods**

Control and intervention groups were selected on

a voluntary basis from groups attending 2 month, 4 month, and six month well-infant visits at the Keesler USAF Medical Center pediatrics clinic. Criteria for exclusion from the study included: families residing further than a 30 mile radius from the base, families reporting plans to leave the area within six months, and families whose child had an underlying chronic disease.

Both groups received a standardized age appropriate slide presentation discussing well-infant care topics. After enrollment in the study, both groups took a multiple choice examination covering topics in childhood fever. The intervention group received an additional ten minute slide presentation on childhood fever after completing their multiple choice tests. The presentation included several topics: the definition of fever, proper measurement of fever in children, adverse effects of fever, management of fever, and situations requiring physician evaluation of a febrile child. The intervention group received a mail-out at one month and three months after their enrollment in the study summarizing the key points from the additional presentation. The intervention group was also encouraged to call the pediatrics clinic to contact the investigator with questions.

Both groups took a multiple choice examination modeled after tests used in previous studies<sup>4,8,9</sup> at the time of their enrollment. Parents were re-tested at two and four months after their enrollment. The tests were also scored by the same person. An example of one of the questions is shown in Figure 1.

#### **Fig 1.**

*Which methods are acceptable for taking a temperature in a child less than 5 years old (May choose more than one answer)?*

- A. Touch forehead
- B. Axillary (under the armpit) temperature
- C. Rectal temperature
- D. Oral temperature

Tests were scored based on the number of incorrect responses. Statistical differences between the test scores for the two groups were assessed using the Mann-Whitney U test. A record review of clinic and emergency room visits was performed by a blinded evaluator to assess for inappropriate utilization. Inappropriate utilization and/or fever management were coded in the following circumstances: failure to contact a physician for a fever present greater than seventy-two hours, contact by the parent for an afebrile child, incorrect antipyretic dosage or dosing interval, and contacting a physician to determine dosage or dosing interval for an antipyretic. Analysis of the derived data was done using the Fisher exact test.

#### **Results**

A total of ninety-three subjects were enrolled -fifty intervention subjects and forty-three control subjects. There was a sizable attrition noted during the study period with only thirty-one subjects completing the study - seventeen intervention subjects and fourteen control subjects. All data reported is derived from subjects who completed the study. Average test score comparisons are shown in table 1. Comparison of the first scores prior to any intervention showed no statistical differences between the two groups. Subsequent test scores did reveal a difference between the two groups with the intervention group performing better than the control group as reflected by an average of fewer incorrect test responses.

An analysis of clinic and emergency room visits for appropriate and inappropriate utilization and fever management skills yielded no statistical difference between the two groups ( $P>0.99$ ) as shown in table 2.

Further analysis addressed utilization patterns of parents in each group examining parents with more than one child versus parents with only one child. Analysis between these two sub-groups in the control group yielded no statistical difference ( $P=0.54$ ) as shown in table 3.

A similar analysis addressed in subgroups within the intervention group yielded a statistical difference. The analysis between the number of inappropriate visits between the two sub-groups ( $P=0.04$ ), shown in Table 4, demonstrated that parents with more than one child had a higher number of inappropriate visits.

Final analyses were done to compare utilization patterns and the status of the study member's active duty sponsor. Branch of service and commissioned versus enlisted status of the study member's active duty sponsor were analyzed with utilization patterns with no significant results identified.

#### **Conclusion**

Fever in children is an area in which misconceptions exist on the part of parents. The study by Schmidt<sup>9</sup> noted that "fever phobia" is an unnecessary burden to parents and strongly urges health care providers to help parents gain a better perspective on fever. The role of the health care provider cannot be underestimated given that 51% of parents surveyed in Schmidt's study<sup>9</sup> reported asking their health care providers for information about fever.

This study, as with similar studies, showed an improvement in parental knowledge demonstrated by improved test scores. This improved knowledge did not translate consistently into improved utilization patterns. There are several possible reasons for the discrepancy

**Table 1**

Test	Average Incorrect Response Control Group	Average Incorrect Response Intervention Group	P value
Test 1	11.4	11.5	0.35
Test 2	11.8	10.4	0.006
Test 3	10.3	8.5	0.002

**Table 2**

Group	Appropriate Visits	Inappropriate Visits
Control	9	8
Intervention	5	6

**Table 3**

Control Group	Appropriate Visits	Inappropriate Visits
First Child	2	1
Subsequent Children	3	5

**Table 4**

Intervention Group	Appropriate Visits	Inappropriate Visits
First Child	6	1
Subsequent Children	3	7

seen between actual knowledge acquired and actions "taken" by the parents. Military members are a transitory group with frequent relocation to new bases which hinders at times development of strong relationships. Typically, there are no family members available for support or advice. The transitory nature is further emphasized by the fact that only one-third of those enrolled in the study completed it despite attempts to contact them by phone. Military health care is readily accessible and has very little cost burden to the military member. Possibly members have become accustomed to utilizing the health care system seeking advice with little effort at home treatment or observation. This habit of rapid utilization may explain why there were fewer numbers of inappropriate visits in the single child subgroup in the intervention group. It could be theorized that the intervention subgroup with more than one child, despite educational intervention, had developed the habit of rapidly consulting the medical system. This data further highlights the need for education to reverse this trend.

The military TRICARE managed care system implemented in the past several years has several goals including offering services such as preventative care and controlling escalating medical costs. The use of childhood fever education in conjunction with other childhood care topics to educate parents will need to be a regular and ongoing part of preventative services to alter current access patterns and help insure the success of TRICARE managed care goals.

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## Obstetrical Outcome in the Very Young Adolescent

Harriette L. Hampton, M.D.  
Rhonda H. Powell, M.D.

### A BSTRACT

#### Purpose and Methods

To determine the obstetrical outcome in adolescent pregnancies younger than 15 years of age. A retrospective multivariate analysis from January 1, 1985 to November 2, 1990 was undertaken. Comparison of all data sets were structured to analyze groups of patients < 15 years of age (group I) or 15 years of age (group II) at the time of delivery.

#### Results

No significant difference was observed between groups for mode of delivery, incidence of low birth weight delivery, or rates of preeclampsia. Group I was less likely to obtain adequate prenatal care. The development of preeclampsia and low birth weight delivery was positively correlated with late entry into prenatal care. Rates of preeclampsia for both groups exceed normal levels for this patient population.

#### Conclusions

Efforts to promote utilization of the health care system are of paramount importance in the very young adolescent age group.

**Key words:** Obstetrical, outcome, adolescent

#### Introduction

Adolescent pregnancy is a major national concern, especially in the southern and south central portions of the United States. In Mississippi during 1990, 21.3% of births were to mothers age 19 or younger.<sup>1</sup> During this same interval only 14.2% of births nationwide occurred in this age group. Considerable data exist concerning the outcome of adolescent pregnancies for mothers 15 to 19 years

of age. From these reports, it has been concluded that perinatal outcome is comparable to adult parturients when early and continuing prenatal care is provided.<sup>2</sup>

However, there is little comprehensive data concerning mothers younger than 15. No conclusions pertaining to pregnancy outcome nor recommendations regarding special perinatal care exist for this very young age group of pregnant women. Annually, 4.2% of deliveries at University Hospital are to mothers 15 years of age or younger.<sup>1</sup> Data from our institution suggests that these mothers may have a worse obstetrical outcome than expected. This study was undertaken to define the perinatal risk of the very young gravida and identify events that can be modified to improve maternal and neonatal health in the young adolescent.

#### Materials and Methods

Between January 1, 1985 and November 2, 1990, 995 deliveries were identified at the University of Mississippi Medical Center that occurred in mothers < 15 years of age. Adolescent gravidas received care from resident physicians at University Hospital, Mississippi Health Department Clinics, or private practitioners. Hollister obstetrical records were the source of antenatal history and hospital records were the source of delivery information. Selected clinical and demographic variables were abstracted from the medical record and inserted into a multiuser sequential query language database. For data analysis, several standard obstetrical definitions were used (Table 1). These included adequate prenatal care, parity, low birth weight (LBW), very low birth weight (VLBW), small for gestational age (SGA), large for gestational age (LGA), preeclamp-

sia, and HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome.

**Table 1.— Definitions of Obstetrical Parameters**

Term	Definition
Adequate prenatal care	> 8 visits
Parity	Infant > 20 weeks or > 500 g
Low birth weight	Infant < 2500 g
Very low birth weight	Infant < 1500 g
Small for gestational age	< 10th percentile
Large for gestational age	> 90th percentile

Statistical analysis used 2 x 2 contingency tables with chi square or Fisher's exact probability calculations, as appropriate, to establish significance for groups of patients. Ordinary analysis of variance was used to establish significance between patient groups for birth weight. A probability < 5% ( $P < 0.05$ ) was considered significant. Comparison of all data sets were structured to analyze groups of patients < 15 years (group I) or 15 years of age (group II) at delivery.

## Results

Delivery outcome and basic demographic information were known in all cases. The ethnic distribution of study patients is presented in Table 2. Black adolescents comprised 88.5% of the total populations, 9.0% were Caucasian, 2.2% were Choctaw Indian, and 0.3% were from other ethnic origins. Incomplete data, however, existed for prenatal care. Only 418 records (44.2%) contained sufficient information concerning the prenatal events to qualify for inclusion. Thus, delivery and neonatal data are derived from a larger database than that used to analyze prenatal care.

**Table 2.— Race of Adolescent Pregnancies By Age**

Age	African-American	Caucasian	Indian	Other
11	1			
12	18			
13	61	1		
14	244	20	6	
15	511	64	14	3

There were no significant differences between groups for mode of delivery. The rates of primary cesarean delivery, outlet forceps delivery, and midforceps delivery were comparable between groups. The indications for cesarean delivery were also similar between groups for cephalopelvic disproportion, abnormal presentation, fetal distress, and other reasons (Table 3). Additionally, the incidence of episiotomy and extensions

of the episiotomy were comparable between the two age groups. No significant difference was observed between the study groups in reference to infant sex or the incidence of SGA and LGA births. Low birth weight infants occurred in 23% of both group I and group II, respectively (Table 3).

**Table 3.— Comparisons of Pregnant Adolescents < 15 Years of Age (group I) with 15 Years of Age (group II)**

Variable	Group I (%)	Group II (%)	Significance
Spontaneous delivery	62.9	64.5	NS
Cesarean delivery	15.9	16.4	NS
cephalopelvic disproportion	41.1	52.0	NS
abnormal presentation	19.6	12.3	NS
fetal distress	30.4	25.5	NS
other	8.9	10.2	NS
Outlet forceps delivery	20.4	18.6	NS
Midforceps delivery	0.8	0.3	NS
Episiotomy	79.8	80.6	NS
Episiotomy extension	20.2	19.4	NS
Male infants	48	52	NS
Female infants	52	48	NS
Small for gestational age	5.3	4.3	NS
Large for gestational age	3.2	4.3	NS
Low birth weight infants	23	23	NS
Preeclampsia	18.4	15.2	NS
Eclampsia	12	4	NS
HELLP	3	5	NS

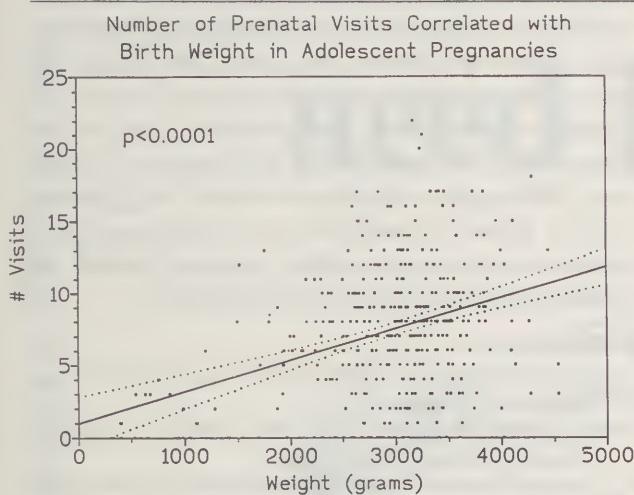
NS, not significant; HELLP, hemolysis, elevated liver enzymes, low platelets

Pregnancy-induced hypertension (PIH) was observed in 18% of adolescent mothers < 15 years old and 15% of pregnancies in 15 year-olds. There were no racial or age related differences between age groups but a trend toward higher incidences of pregnancy-induced hypertension was observed from Caucasian to Black to American Indian ethnic groups. Eclampsia was observed in 12% of group I patients with PIH and 4% of group II patients with PIH, but these differences were not significant. HELLP syndrome was also equivalent between groups, affecting 3% of group I and 5% of group II patients.

As a subgroup, LBW infants occurred more frequently in women who received no prenatal care ( $P < 0.001$ ). These high-risk infants were seen in 36% of group I patients and 35% of group II adolescents who had no health care prior to delivery. No LBW infants were delivered by Choctaw mothers. Choctaw infants were significantly heavier (mean =  $3556 \pm 83$  g) than all other races ( $P < 0.001$ ). However, mean birth weights for the University of Mississippi Medical Center patients (mean  $2825 \pm 25$  g) were not significantly different from a comparative group of adolescent mothers previously re-

ported.<sup>3</sup>

To assess the influence of prenatal care on the occurrence of preeclampsia, the gestational week of the first prenatal visit was correlated with the onset of preeclampsia in 77 pregnancies (Figure 1). Linear regression revealed that preeclampsia was positively associated ( $P = 0.002$ ) with late entry to prenatal care.



**Fig 1.** Onset of preeclampsia correlated with week of first prenatal visit ( $P = 0.002$ ,  $r^2 = 0.12$ , 95% confidence interval shown).

Adequate prenatal care (> 8 visits) was documented in only 56% of the study population. Patients with no prenatal care accounted for 11% of patients in which care status was known. When subdivided by ages, significantly more ( $P < 0.05$ ) very young adolescents obtained no prenatal care (14.5%) than did the 15 year-old group (7.5%). Similarly, adolescent patients were less likely (11%) to receive prenatal care than all (1.2%) Mississippi parturients ( $P < 0.001$ ).

Finally, the number of prenatal visits was assessed in comparison with birth weight in an attempt to assess the impact of prenatal care on this young adolescent patient population (Figure 2). There was a positive correlation between the number of prenatal visits and birth weight. A linear regression analysis indicated that this correlation was different than zero ( $P < 0.0001$ ).

#### Discussion

The purposes of our study were to characterize the pregnancy outcomes of two adolescent pregnant populations and to determine whether the very young adolescent parturient (< 15 years of age) was at increased risk for adverse obstetrical outcome relative to the 15 year-old group. Our experience represents 16% of births to state residents < 15 years of age during the study interval. The 15 year-old group served as our control, since reproduc-

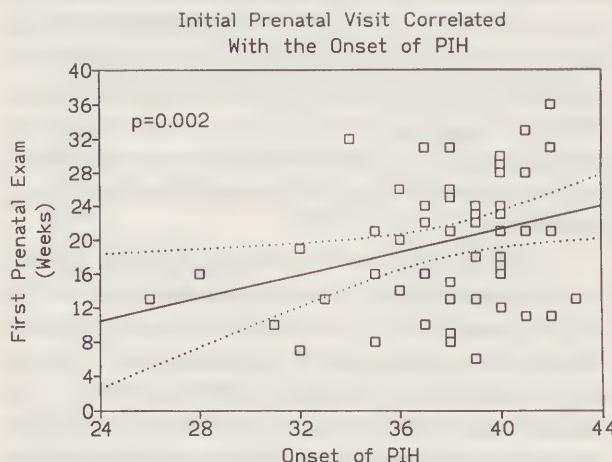
tive performance in this group has been well studied and shown to be the same as adults when controlled for race, socioeconomic status, and prenatal care.<sup>2</sup> Furthermore, use of this 15 year-old control group is a more appropriate construct than use of older adult controls since these younger patients have achieved educational and maturation levels more comparable to those of the very young adolescent.

In Mississippi, births to adolescent Black mothers outnumber adolescent Caucasian births 2 to 1.<sup>1</sup> The indigent population served by the University Hospital had a higher percentage of Black adolescent deliveries (88.5%) and fewer Caucasian deliveries (9%). The Choctaw experience is unique to the University Hospital since this native American population contracts for delivery at our facility.

Access to prenatal care is not a significant problem in Mississippi. Only one county had no prenatal care provider in 1988.<sup>4</sup> Most pregnant women in Mississippi (75.3%) seek care in the first trimester of pregnancy. This data mirrors national statistics for the South where 73.4% of pregnant mothers present for care in the first three months of pregnancy.<sup>5</sup> Only 20% of our very young adolescent study patients, however, presented for care in the first trimester. Adequate prenatal care, as defined by > 8 prenatal visits, was documented in 48% of group I patients and 51% of group II patients in our study. Delayed entry into the health care system is felt to be multifactorial and probably is related to a desire to conceal the pregnancy, not recognizing pregnancy, and not realizing that prenatal care is valuable or available.

The greatest obstetrical risk for the pregnant adolescent is delivery of a LBW infant. National statistics indicate that Mississippi has an 8.7% incidence of LBW deliveries for all gravidas.<sup>5</sup> This contrasts markedly with a 20% incidence of LBW deliveries in adolescent mothers nationwide and 23% incidence of LBW babies in our study population.<sup>4</sup> Pregnancy-induced hypertension was a factor for LBW in 24% of cases in group I and 17% of births to mothers in group II. Very low birth weights (< 1500 g) comprised 47% of the LBW group for group II and 39.4% for group I. Prenatal care positively influenced birth weight (Figure 2) in both PIH and normotensive patients. This data reinforces the premise that early prenatal care is the best defense against preterm birth and early recognition of PIH in the adolescent patient.

Most reports indicate that the adolescent population does not have a higher incidence of preeclampsia than matched adult controls. Our finding of an 18.4% incidence of preeclampsia in group II and 15.2% in group I contrasts with studies by Clark and Graham reporting an



**Fig 2.**— Correlation of the number of prenatal visits with birth weight ( $P < 0.0001$ ,  $r^2 = 0.05$ , 95% confidence interval shown).

incidence of 1.1%<sup>6</sup> and 7.9%,<sup>7</sup> respectively in an adolescent indigent population. As demonstrated in Figure 1, the incidence of preeclampsia in our study correlated positively with first prenatal visit ( $P = 0.002$ ). It is uncertain whether the disease process prompted the entry into the health care setting or the delay in care was a contributing variable.

Prior obstetrical studies have suggested a higher incidence of cephalopelvic disproportion in the very young adolescent.<sup>8</sup> Neither group in our study population was at increased risk for cesarean delivery. Cesarean was the mode of delivery in 15% of group I and 16.5% of group II patients with a corresponding institutional primary cesarean rate of 17%. Cephalopelvic disproportion was the most common indication for cesarean delivery followed by fetal distress and abnormal presentation.

Most patients underwent vaginal delivery or were assisted by outlet forceps. In patients that underwent vaginal delivery, extension of episiotomy was recorded in 20% of deliveries in contrast to the overall institutional figure of 7%. No morbidity occurred, however, in patients with reported episiotomy extension.

Birth weights for Black and Caucasian adolescents did not differ significantly from prior reports.<sup>3</sup> A trend of increasing weights with age was observed, as well as larger birth weights for Caucasians than the Black population. Significance was observed, however, for the native American adolescent ( $P < 0.02$ ) when compared with Black and Caucasian infants. The large birth weights for the native American females occurred in the absence of glucose intolerance, a common finding in the adult native American patient.

## Conclusion

Our study indicates that the very young adolescent is at high risk for a LBW infant and preeclampsia. Contributing factors include delayed entry for health care and inadequate antenatal follow-up. Only one in five patients in our study obtained prenatal care in the first trimester. Birth weight was positively associated with time of entry and frequency of prenatal care. Preeclampsia likewise correlated with late presentation for prenatal care. Efforts to promote utilization of the health care system in this age group are of paramount importance for the health of the infant and the individual. The national goal to reduce the incidence of LBW infants to 5% in the year 2000 cannot be achieved without an aggressive effort to define the obstetrical risks of the very young adolescent and to seek realistic solutions towards the achievement of early intensive perinatal care.

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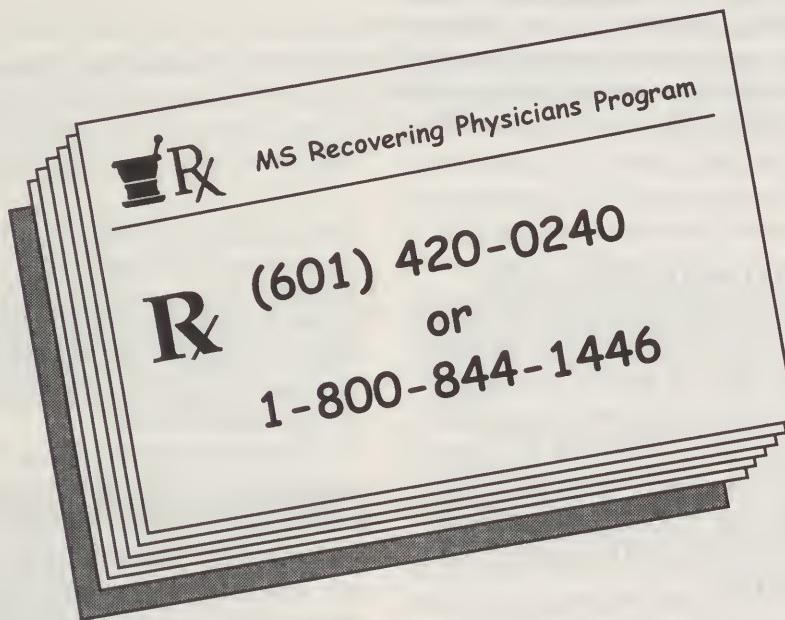
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# “RU Y2K Ready?”

*[Throughout the year the JOURNAL MSMA has published excerpts to help you prepare to deal with potential Y2K (Year 2000) problems from **The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice**, published by the American Medical Association, 1999. With the new millennium now upon us, here is a final recap to help you anticipate problems which might stem from computer systems that are unable to correctly read the year 2000 where they must use a date—Ed.]*

## E SSENTIAL PROVIDER TASKS

At this late point in time, it is essential that anyone starting this procedure also develop alternate operating plans, i.e., contingency plans, in parallel with the other steps. Since partners or other parties may be susceptible to millennium events, it may be advisable to consider contingency plans which are two or three deep in alternatives. Given the variables and unknowns associated with the year 2000 rollover, it would be prudent to back up your electronic data files.

### The Bottom Line for All Providers

Look around your medical facility or office to identify Y2K problems and remedy them. There is an absolute minimum you should personally do, if you lack the time, resources, or authority to fully correct the Y2K problems in your facility or practice. Namely, think about what you absolutely require to be able to care for patients and make sure they will not experience Y2K problems in January, 2000, especially if any of this equipment or these services rely on embedded computer chips. You must create a contingency plan (alternate operating procedure) to work around them should Y2K problems cause them to fail.

### Quick Year 2000 Test

It is estimated that nearly 80 million PCs will not properly rollover the date from December 31, 1999 to

January 1, 2000. This is approximately 80% of the PCs in operation. The PC's age or recency of purchase is not an indication as to the year 2000 compliance. All PCs, new and old, must be tested.

The following procedures are quick methods to determine if your PCs BIOS is year 2000 compliant. The BIOS is the part of the computer that manages the system clock and reports back to software applications the current date and time when an application requests it. Two different year 2000 related problems will be tested with these procedures, the January 1, 2000 problem and the February 29, 2000 problem.

The BIOS on many computers will not properly recognize the rollover to the new century. Many of these computers will reset their clocks to the earliest date they were programmed to handle (January 1, 1980). To test your PC for the year 2000 problem, perform the following test:

1. Set the date on your PC to December 31, 1999 and the time to 23:55hrs (11:55pm) and then shut down the computer in the normal manner and turn the POWER OFF. Turning the machine off is a required part of this test. Hitting the reset button is not sufficient. Many machines behave properly if they are not turned off during the century rollover.

2. Wait at least 5 minutes and then turn on the PC.
3. Verify that the date is Saturday, January 1, 2000 and the time is a few minutes past midnight.
4. If the day of the week, date or time is incorrect, you have a problem with your system BIOS. This may require a software upgrade to the BIOS or a BIOS chip replacement. Contact the manufacturer of the computer to obtain the upgrade.
5. Repeat the same test without shutting down the machine and turning off the power.

### Leap Year Test

The year 2000 is also a leap year. The last time a leap year occurred at a century mark was in the year 1600. Many systems were not programmed to properly recognize the year 2000 as a leap year. To test your PC for the year 2000 leap year problem, perform the following test:

1. Set the date on your PC to February 28, 2000 and the time to 23:55hrs (11:55pm) and then shut down the computer in the normal manner and turn the POWER OFF. Turning the machine off is a required part of this test. Hitting the reset button is not sufficient. Many machines behave properly if they are not turned off during the century rollover.
2. Wait at least 5 minutes and then turn on the PC.
3. Verify that the date is Tuesday, February 29, 2000 and the time is a few minutes past midnight.
4. If the day of the week, date or time is incorrect, you have a problem with your system BIOS. This may require a software upgrade to the BIOS or a BIOS chip replacement. Contact the manufacturer of the computer to obtain the upgrade.
5. Repeat the same test without shutting down the machine and turning off the power.

The BIOS is not responsible for date manipulation, date math or other date related functions that are performed by software. It is possible for the PC BIOS to handle the year 2000 properly and the application software using the date to mishandle it and cause problems. The above test will only determine if the system BIOS is functioning properly.

### Testing of Claims Processing for Medicare Providers

The Health Care Financing Administration (HCFA) requires all Medicare contractors (fiscal intermediaries and carriers) to make available to physicians and all other providers and suppliers (claim submitters), the opportunity to future date test their claims data exchange process with the Medicare contractor.

Providers have been urged for quite some time to contact their Medicare contractor to arrange for system testing. Upon a provider's request, the Medicare contractor will accept Year 2000 future dated test submissions, such dates as 01/10/2000, 02/29/2000, etc., perform standard front end editing on the submissions, and return the edited transactions to the submitters. This testing will provide assurance to both HCFA and providers that provider claims processing/data exchange systems are working and ready for Year 2000 operations.

For a front-end acceptance test of your claims submission process with either the carrier, intermediary, billing service, or clearing house to be of value to your Y2K preparations, you must receive feedback about the tests results. Without this information, you have no documentation of the results of the test. The documentation will be useful to ensure that the test was successful or to use the information as a basis for taking corrective actions.

Verify the readiness of your practice management system with your vendor if relevant and assess any local code you have added or purchased from a local vendor.

One of the Medicare contractors conducting tests of provider systems has found that a number of tests failed due to significant problems in provider/submitter internal systems. These problems, left uncorrected, could delay reimbursements to these providers beginning January 1, 2000.

Because it is so very important, HCFA urged all providers to have their systems tested earlier this year. It was hoped such action taken then would avoid a last minute rush, allow adequate time to test and remedy any problems found, and eliminate disruptions and problems with cash flow. Remember, the Health Care Financing Administration does not assume any responsibility for your Y2K compliance.

### Office Operations

The links below are to pages that contain links to various companies' Y2K web sites. At these web sites, information can be obtained about that company's products and whether they will experience Y2K problems.

- The EDS (Electronic Data Systems) Website includes information on more than 160,000 products at <http://www.vendor2000.com>.
- The Y2K Compliance Database at <http://www.y2kbase.com/y2kbase/vendor.html> contains links to many computer products manufacturers' Y2K web pages (Hewlett-Packard, Ricoh, Sanyo, Texas Instruments, Xerox, Canon, Pitney Bowes, etc.).

### **Business Partners**

Contact your business partners to ask them if they have prepared for Y2K problems. Ascertain whether they have developed contingency plans in case their businesses are affected by Y2K problems.

According to the HCFA Y2K Coordinator, there are some complicating factors of common solutions to Y2K problems that each organization should keep in mind when assessing the readiness of their business partners. The factors concerning the absence of a **standard pivot year to use for windowing and the data exchange agreement issue** were important. It is vital for business partners to communicate to each other what types of solutions are being used for their data exchange systems. If different solutions are used, and even if the solutions render both systems to be compliant, there may be substantial data exchange problems between the business partners.

### **Contact Other Major Third Party Payers**

The above considerations are equally applicable for transactions with your other payers. Contact them directly to arrange Y2K testing.

### **Other Suggested Steps Toward Y2K Readiness**

Inventory your practice for other Y2K problems. Anything that depends on a microchip or date entry could be affected, whether it belongs to you or to an organization you depend upon. The attached checklist, which can also be found on the HCFA website ([www.hcfa.gov/y2k](http://www.hcfa.gov/y2k)), will help you in this inventory. Don't forget to:

- Identify your mission critical items, that is, those items without which you cannot run your practice and focus on those first.
- Contact the vendors and service contractors for your computer hardware and software, service companies such as your security company or paging system, and your medical equipment suppliers (EKG machines, for

example, may actually give inaccurate diagnostic results) to obtain information regarding the Y2K status or impact on their products.

- Update or replace systems, software programs, and devices that are not Y2K ready and that you decide are critical for your business continuity. There is no time to lose on this activity as the replacement systems you need may be back-ordered.

- Keep notes on all your communications and testing information for possible use later and do not assume that a system or a program is Y2K ready just because someone said it is for critical items, get assurance in writing and/or attempt to have them tested.

- The original manufacturer of a product knows the product best and is in the best position to assess the Y2K status of it and provide advice. Industry experts recommend that you not test biomedical devices until you have checked with the supplier or manufacturer to determine the advisability of such testing. Particular attention should be given to interconnected devices or systems whose components share or communicate data and that are not from a single manufacturer or source.

### **Develop Business Contingency Plans in the Event Something Goes Wrong**

#### ***Focus on the Things That Would be Most Problematic for You and Your Patients***

While storing claims information on paper may be a part of your contingency, actually submitting them for payment is ill advised, as an enormous increase in paper claims cannot be accommodated by payor systems, and this could significantly delay your payments. It is has been recommended that your billing office work with your carrier to create the appropriate electronic contingency.

#### ***Understand the Issue so That You Can Assure Your Patients of Continued Quality Care.***

Become informed about your office's readiness for the Year 2000. If any patients develop concerns about how Y2K may affect the continuity of their health care, they will be greatly reassured by informed responses from you and your staff. Be prepared to answer specific questions regarding Y2K readiness by patients.

For more information: *The AMA Coordinating Center for the Year 2000 Problem* <http://www.ama-assn.org/not-mo/y2k/index.htm> offers member physicians the finest available information for recognizing

and dealing with the problems caused by computers and the new millennium.

## Additional Websites Offering Y2K Guidance

- The Food & Drug Administration (FDA) website, [www.fda.gov/cdrh/yr2000.html](http://www.fda.gov/cdrh/yr2000.html), offers an extensive listing of the status of medical equipment readiness, by manufacturer.

- The Rx2000 Solutions Institute is a web site created specifically for Year 2000 and Healthcare issues. [www.rx2000.org](http://www.rx2000.org) is available free to all and includes articles, publications, presentations, help in communicating Year 2000 issues, local/regional health care executive briefings, listings of vendors of Year 2000 products and services, education listings, case studies, as well as what other health care organizations are doing.

- The General Services Administration (GSA) website, [www.itpolicy.gsa.gov/mks/yr2000/y2khome.htm](http://www.itpolicy.gsa.gov/mks/yr2000/y2khome.htm), offers valuable information to assess your building and infrastructure.

- The Small Business Administration (SBA) website, [www.sba.gov/financing/fry2khtml](http://www.sba.gov/financing/fry2khtml), offers information on how to obtain SBA-guaranteed bank loans that may help small, for profit providers pay for a variety of Y2K-generated needs, including: Y2K adjustments, repair, and acquisition of hardware, software, and consultants.

## Toll-Free Line Provides Y2K Information to Consumers

The President's Council on Year 2000 Conversion introduced **1-888-USA-4-Y2K**, a new toll-free Y2K information line, and other Council initiatives for providing consumers information about the Year 2000 computer problem. 1-888-USA-4-Y2K offers information of interest to consumers in common areas such as power, telephones, banking, government programs, and household products. Information for the line comes from primary sources: government agencies, companies, or industry groups. Pre-recorded information, which is available seven days a week, 24 hours a day, is available on the most common topics, and information specialists supported by researchers are available to provide additional information to callers. Information specialists will staff the line from 9 a.m. to 8 p.m. (EST), Monday - Friday.

## SAMPLE PROVIDER Y2K READINESS CHECKLIST

*This checklist is intended as a supplemental guide to help you determine your Y2K readiness. Consider using this along with other diagnostic and reference tools you have obtained for this venture. The purpose of this checklist is to aid you in determining your Y2K readiness. This information is not intended to be all inclusive.*

ITEM	Y2K READY	NOT Y2K READY
Appointment scheduling system		
Answering machines		
Bank debit/credit card expiration dates		
Banking interface		
Billing system		
Building access cards		
Claim forms and other forms		
Clocks		
Computer hardware (list)		
Computer software (list)		
Custom applications (list)		
Diagnostic equipment (list)		
Elevators		
Fire/smoke alarm		
Indoor lighting		
Insurance/ pharmacy coverage dates		
Medical devices (list)		
Membership cards		
Monitoring equipment (list)		
Office forms (claims, order, referral)		
Outdoor fighting		
Paging system		
Payroll system		
Physician referral forms		
Security system		
Smoke Alarm		
Spreadsheets		
Sprinkler system		
Telephone system		
Television/VCR		
Treatment equipment (list)		
Safety Vaults		



## Good News (Luke 2:10)

### W. Briggs Hopson, Jr., M.D. The President's Page

T

he angels said to them, "Do not be afraid for behold I bring you good news of great joy which will come to all people." As we of the Christian faith begin to celebrate this Advent season, let us stop for a few moments and think about the blessings that we have received and the good news which has come to us. This quotation comes from the book written by St. Luke, who a number have called the dear and glorious physician. His writings were certainly those of a learned man, a man who had spent the time to research what had happened and what had gone on before him prior to sitting down to write and put things in chronological order. As he writes to Theophilus, he begins by telling him that this has been researched and written according to the findings that he gathered throughout his journey. I feel the message that we as physicians should learn from this is that we should gather information as we travel the highways of healing, gleaning and sorting information that will help us improve what we do each day. We should record that information in chronological order so that those who follow us can utilize this information in caring for those who are ill in order to improve the treatments and treatment modalities. St. Luke also researched the information that he obtained, and so should we in our ever changing field of medicine. It is amazing what has been accomplished in the 20th century, and all of us know even more will be accomplished in the 21st century.

However, we also know, despite all that we do, we cannot give eternal life and that all of us reading this article will eventually die and leave this earth. I believe the thing that sets us apart as healers is that we, in our short time here, have the opportunity to prolong a life and make it better. As we continue to work and serve, hopefully, we are able to ease someone's suffering and to help someone with a disease that seemed incurable or unbearable. Even more than that, I hope we have given thoughtful advice, sincere comfort, and have stopped daily and reflected upon the great physician who healed by caring, by touching, and through genuine concern. I also hope that each of you will support organ donation and encourage your patients to "live and then give." What greater gift at this time of year than an organ or tissue to help someone live!

It is my wish to each of you that YOU have a joyous Christmas season and that as we begin a new millennium, we will approach it with the same fervor of those who approached millenniums before us—with thought, with prayer, with care, and realizing that all we have comes from those who labored in the fields before us.

A handwritten signature in black ink, appearing to read "Briggs".

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## "COMMUNITY SERVICE"

Even the New Testament writer James seemed to recognize its importance. In his letter's second chapter, James posed the question, "What good is it, my brother, if a man claims to have faith but has not deeds?" He later provides an answer declaring,... and faith by itself, if not accompanied by action, is dead."

Perhaps this passage is among the earliest references commending community service. After all, besides the given of providing quality healthcare, what better way do we as physicians have to thank our patients and our communities for their confidence, support, and kindnesses (those already-shelled peas, those already-dressed fish, those already-reserved high school football tickets) than by involving ourselves in community service?

However, a recent personal experience has underscored the apparent fine line between community service and masochism. The idea seemed noble (and innocent) enough: Local businesses would sponsor unique fund raisers for the American Cancer Society's Relay for Life. An anonymous clinic staffer came up with the brilliant idea of posting containers around town asking donations in the names of our various physicians. The kicker? The "high roller" would earn the dubious honor of kissing a pig on the town square on the evening of the big event.

Even a death row prisoner has had years to contemplate his fate. Me? How about an hour's notice that I was the lucky winner? But if you know me, you know that I couldn't show up and JUST kiss a pig. So my "Top Ten Questions You Ask When You're Gonna Kiss A Pig" couldn't have been delivered more enthusiastically by Dave Letterman himself:

10. What do you wear when you're gonna kiss a pig? (My T-shirt with pig motif and visor with pigsnout bill made a strong fashion statement)
9. Just how much money was raised for me to kiss this pig? (Not nearly enough)
8. Am I the first guy to kiss this pig?
7. Does this pig really want to be kissed?
6. Will this pig kiss and tell? (Or squeal)
5. Has President Clinton ever kissed a pig?

*The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.*

4. Is this the Little Pig that went to market?
3. Do you close your eyes when you kiss a pig? (Not necessarily but you certainly hold your nose)
2. Will this pig respect me in the morning?
1. Will my wife ever kiss me again?

Her name was Tenderloin. But any hope of bussing a Babe-like creature quickly vanished as the trailer hauling my large, smelly, uncooperative date pulled into place. When the stubborn sow refused to budge, our tryst was forced inside the trailer, and with the rambunctious hog pinned between his leg and the rail, the owner whispered some sage advice, "If I was you, I'd kiss her real quick on the head!"

Oh, the commitment is still there. But my effort next year will include hefty contributions to my partners' coffers so that they too can experience the "warm, fuzzy" feeling associated with community service.

*—D. Stanley Hartness, M.D.  
Associate Editor*

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# Mississippi State Medical Association

## MSMA President Calls Meeting to Discuss Component Societies



MSMA President W. Briggs Hopson, Jr., MD, Vicksburg, recently called a meeting to discuss mutual affairs of the association and component societies. Eleven of the sixteen MSMA component societies were represented by at least one of their officers.

"I think everyone who attended the above meeting called by the association's President, Dr. Briggs Hopson, felt that it was extremely beneficial," said MSMA Executive Director William F. Roberts. Eleven of the sixteen MSMA component societies were represented by at least one of their officers. A brief summary of the discussion follows, together with some ideas that were discussed which might help improve the level of component society participation and effectiveness:

### Current Levels of Society Involvement

Approximately half of the societies said that attendance at their meetings was satisfactory or good on a fairly consistent basis. The others said that their attendance was generally poor and mostly in a state of decline. Almost all of the societies indicated that they had accumulated significant funds because the expenses for conducting their meetings had declined over the years because of reduced attendance.

### Demographics of Participants

Most of the societies that are having problems with

attendance are also having a problem in attracting younger physicians, while those who have good attendance either had a majority of younger physicians or a good mix of all age groups. One society indicated that it was having a problem in getting the more experienced physicians to participate. Generally, everyone agreed that the more active members in each society are those who are self-employed and that participation by female physicians is very poor.

### Meeting Format and Program

There was no real consensus on the type of meeting format and program that would likely be most effective in generating increased attendance. Some societies said that attendance was poor regardless of the program topic or speaker. Some said that their members had no interest in attending a mostly social gathering that involved no discussion of significant issues, while others said that reducing the amount of business and emphasizing the meeting as a social event had proven to be very successful. Many society meetings include scientific presentations spon-

sored by pharmaceutical companies, but with varying degrees of success. Everyone generally agreed that arranging a separate program for the spouses during the members' business meeting was not productive, effective or popular.

### Need for Administrative Support

It was noted that only one of the 16 component societies has staff support, and that this impedes the ability of those without such support to efficiently handle the responsibilities associated with arranging society meetings and taking care of other administrative duties. It was suggested that MSMA consider designating one of its staff or employing someone part-time to provide administrative support to the component societies. There was also a general consensus that the component societies would be willing to fund this position by allocating a portion of their dues on a per member basis. MSMA agreed to look into the possibility of doing this.

### Important Factors in Successful Society Meetings

Despite the fact that there was no consensus on the best format or program to ensure the success of component

society meetings, everyone agreed that the following factors are important to the overall effectiveness of a component society and the success of its meetings:

Electing someone to the office of Secretary who is willing to commit the necessary time and attention to the position, and then allowing him/her to hold the office for an extended period of time.

Providing as much advance notice as possible about a scheduled meeting, and soliciting the assistance of local MSMA Alliance members in making follow-up phone calls to encourage attendance.

Keeping the meeting to a reasonable length of time, having it at a good location that is conducive to social interchange, and providing a good meal.

Eliciting the assistance of the MSMA staff in identifying potential program topics and speakers.

### Future Meetings

Everyone agreed that this meeting was very productive and beneficial, and that another one should be conducted, perhaps during the association's 132nd Annual Meeting next May and at each Annual Meeting thereafter.

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## **Dr. Hopson Concludes 1999 Component Visit Schedule — Next Stop: North Mississippi Medical Society- January 20, 2000**



*Central Medical Society President James R. House, Jr.; President-Elect Thomas E. Joiner and Secretary-Treasurer Gerhard Mundinger*



*MSMA President W. Briggs Hopson, Jr. M.D. addresses Central Medical Society at River Hills Club in Jackson*

### **Excerpts from Dr. Hopson's Address to Central Medical Society**

"When one of us loses we all lose and we know what happens when we let others infringe on our scope of practice. If you look at the groups such as the podiatrists, the chiropractors, the nurse practitioners, the pharmacists, and as the list goes on and on, we see Allied Health. People are really wanting to take a part of our practice of medicine. This is something that we can not let happen. If we as physicians let our guard down rest assured those people will take a piece of our practice and before long as they nibble at it, we will have less and less to do as we practice medicine. One of the things that I think that we have is fantastic lobbying efforts in our legislature. Your Mississippi Medical Political Action Committee (MMPAC) and I have worked with our legislative people to see that doesn't happen. Again, it is a continuing effort though. Just because we do it one year, it doesn't mean that we stop and don't have to do it the next year. We will be looking at this and asking again for your support as we try to keep people from breaking in on the practice of medicine.

"Another thing that I think is a real issue to all of us is the loss of revenue. Again, we as physicians realized

that with a number of changes in the federal program relating to the Balanced Budget Act, change in Medicare and Medicaid, all of our revenues are just statically going down. In fact, the physicians are one of the few groups in the United States whose income has not kept up with increases as far as daily living, and as far as the consumer price index and adjusted cost of living. This is something that we have to press, both with our legislators here and our legislators nationally to at least look at what they are doing to us with regard to the practice of medicine.

"The third thing that really troubles me is that not only do we have those problems, but when we look at perception of physicians, we are starting to lose our place with where we stand on the ladder of where physicians are perceived nationally. I think we, as one of our members here at Central Medical said last year, 'we were only one rung above the trial lawyers.' And that is really sad when you think about that. That people perceive us that way, though - not as they did 20 or 30 years ago but where we stand now. I know that we need to look at hospitals and other entities such as large groups trying to take over physician practices. We lose some of our individuality and some of our ability to deal with patients. We have become just another employee in the system of medicine. Again,

this is something that all of us need to look at as we look at where we are going in the next year, not only locally but nationally. Now, these are problems that all of us face; and we can only solve those problems if we work together to solve them. Those of you who were at the dedication of the new state office building heard me say when I was there 'that eleven brothers are hard to beat.' That was a sign that used to go across the Warren Central dressing room when



*Dr. Hopson and his wife, Pat.*

I was the team doctor, and certainly, the only way we can solve these problems is if we stick together as physicians and try to really work together to fight these issues. I think unity is what is holding us together and unified we can accomplish a number of things. Again, when our adversaries try to fragment us, that is when they get a toe hold and we really lose where we are going and what we are doing."

"There are several things that I would like to comment on about what your State Medical Association is doing. I know that we have one of the best state medical associations in the country, and I think that our state medical association is working trying to give you what you need as a practitioner to deal with these problems.

"Number one, as I mentioned earlier I think that we have a fantastic lobbying effort with Charmain Thompson and Linda McMullen. They have done a super job lobbying for us and our state legislature is keeping us abreast of what is going on nationally with things we need to address... We were very fortunate last year in what we achieved in the legislature. It was probably one of our best legislative years ever due to lobbying efforts and through your support we were able to establish the Tobacco Trust Fund, get the Children's Health Insurance Program funded, get the Trauma Care Program funded, and get increased payment on Medicaid for everyone in this room. Those were great accomplishments, but we can't stop. If we stop we will have all of the people that are nibbling at us take a piece of this. So, number one, I want you to ask yourself, your spouse, your friends, your patients, are they voting for someone who is going to help medicine and help us with what we are doing in medicine.

"There are several things this year that we already have on our legislative agenda. One of the things that we thought that we were going to have to press and again this had gotten to be 'icky' was what we were going to do about the Governor's veto about appointing an advisory committee for Medicaid patients. I don't know if some dove got on his shoulder or God gave him a message or what, but recently the Governor appointed a commission after he vetoed the Bill, and he did appoint several doctors on this commission and hopefully, we will be able to advise the Medicaid Director on what is going on. Most of you in this room know that Helen Wetherbee who used to run the Medicaid Commission for years retired recently. At the present time, the Governor appointed one of his staff people, Anna Marie Barnes, to take over as Director of Medicaid. I am certain that whoever the Governor elect is that there will possibly be another appointment come January or February of this year. Again, it is critical that physicians have some input into what happens with regard to Medicaid in this state. And this is another reason that you need to be very vocal in what you do politically and how you support your politicians.

"One of the other things that we are going to push this year in the legislature is requiring all people who have a license not just to put Doctor so-and-so but actually, we are going to ask them to specify what their license is when they advertise and when they put something in the phone book. Just not say, "Call Doctor so-and-so". He may be a doctor of 'whatever'. We want to put M.D., D.O., Ph.D., whatever they are putting doctor for. We are going to try to push for electronic signatures on all medical records and hopefully we will get that passed. We are going to also solicit, which we have been doing, input on the tobacco trust fund money. As most of you know a number of people are trying to nibble

away and take a part of tobacco trust fund money away from health care. I think that everyone in this room realizes that money was designated for health care. All of us want it to stay in health care; but some people say that if you build roads to go to the hospital that is health care. That is not health care folks, and anybody thinks it is health care really doesn't need to be in the legislature; but a number of people say that is health care. We need to have an advisory committee that looks at the tobacco trust fund money; and hopefully, the new Governor will appoint a committee that deals with this, and works with this, and will give us some input into where this money is spent and how it is spent and to continue to use it to take care of people's health in this state.

"A number of societies that I have talked with and a number of groups are suggesting things to us that we need to lobby for this year. Again, we ask your input in this. We try to take what the physicians of Mississippi want to the legislature. Charmain and I talked to a group of family practitioners that wanted us to really push for physicians' assistants which we have for years. I think that everyone in this room knows that we are the only state in the union that really does not have physicians assistants licensed under some form of governmental control by the State Board of Health or someone here. Again, we lobby against the nurse practitioners. We are willing to push for that if wanted. However, if we push for it, we probably will not get it, but if that is what the group wants we will do it. They asked us to lobby for it and if the majority of people want medicine in this state; rest assured we will push for that and lobby for that. We want to be your advocates and lobby for the things that you want us to lobby for.

"Again, we, across the state, are trying to increase membership. I was tickled to hear Jim (House) announce all of the new members that you have. I think it is a real plus for any medical society to have new members; and the thing that really made me feel good was so many of new members were young folks just getting out of residency. I tried to recruit Pat Scanlon to Vicksburg. He turned me down and came to Jackson. I don't know if I can forgive him for that. I know he is glad to be here, and we are glad to have him close to Vicksburg any way. I am interested and happy to see young people involved about the society activities. Nonetheless with this gray hair on top, we are getting to the age that we need young folks to come on the scene and do some of the things we did 20 or 30 years ago. Hopefully, you will continue to push the young people to get involved in Central Medical Society. About six weeks ago, I asked all of the presiding presidents of medical societies to come to the state office and meet with us. We had a meeting to talk about declining membership in all of the societies. That is not just here. It is not just in Vicksburg. It just not in Homochitto Valley. I mean it is everywhere. We had some great ideas and great thoughts and in fact, the meeting went so well, that we want to try to have another one with the State Medical meeting on the Coast this year. Again, it behooves all of us to try to get people involved in organized medicine. If we sit back and don't do this, rest assured other organizations will do it, and we can go to locker rooms and to coffee rooms in the hospitals and complain about "hey, everyone is doing this to us as physicians; but if we don't get together, work together, and we complain about it and don't get unified, we are going to have problems. So, again, I am pleased to see you with increasing membership. Hopefully, you will continue to encourage your new members to get on board, get involved, and try to increase your membership. As your State Medical Association we are trying to do several things. One, we are trying to improve our web site with new information to physicians that they can get off the web, which I think will be a benefit to all of you. We have put together a third-party liaison committee, which I am just tickled to death with. We had our first meeting last week, and it was one of the best meetings I have ever been to. It was really a group of five people that want to do what is right for physicians and help physicians resolve problems with insurance companies. Alabama has had this model for the last several years. Linda McMullen and Jackie Wiebelt from the office went over and meant with them, got all of the information. What we are going to do with this committee is try to work on negotiating problems that physicians have with insurance companies or if insurance companies have problems with physicians we will negotiate so these problems don't go to court. We think that would be a real plus for you ..... and State Medical Association.

"Certainly, another thing that we have done is that we signed a contract recently with Butler, Snow, and O'Mara Stevens & Cannada, one of the law firms that have offices across the state, to work for physicians on their behalf on contract negotiations, on practice negotiations, on working with problems that you have on any page where you need legal help, you can get this help by calling the office, and you get a reduced rate if you need to work with them on any issue you have. I think one of the real pluses to the State Medical is MPCN, and all of you are members of MPCN, and I believe MPCN is the best PPO in the state. I think we do a fantastic job. We just signed a contract to work with a huge

group in Alabama that has a large number of employees involved, and I know this will be a big plus for our State Medical Association as we go forward trying to get more and more people involved.

"I told Jim that I would comment on a couple of things tonight. One thing I want to comment on is the Patients Bill of Rights that is on the floor of Congress right now. Most of you are aware of the fact that the Senate passed a water-downed version of the Patients Bill of Rights. Charmain and I went up and talked to our Senators. Did everything that we could to try to convince them that they needed to quit thinking about insurance companies, they needed to quit thinking about HMOs, and they need to quit thinking about business. They need to start thinking about the patients. You know it is amazing we say that the patient-physician relationship is the cornerstone of medical practice. Patients are people. And folks when you forget that patients are people like our two senators then you've got a problem. In fact, one of our senators looked me right in the face and said, 'Briggs, you are exactly right on what you want to do; but I can't vote for it. I've got to vote the party line.' And that is really sad when someone tells you that they know you are right, they know what you do for people is right, but they are going to vote for party line, vote Republican line. I have a real problem with that scenario. Now .... I can assure you that .... will never change, and I hope I live long enough to see that change. If we don't stand unified folks, we are not going to get this accomplished. If we don't get the people that we treat to call the senators and the congressmen, we are going to be sitting here floundering on this. Now, the week before last, Pat Barrett, Susan Pickard, several other members, Charmain and I went to Washington to lobby congressional folks. We received a little better reception in congress because they had a few democrats there that we could talk to. We at least got the democrats .... to sign on to the Norwood..... Bill 2723, that Jim mentioned, the Bill that does what we need it to do for patients. Now, that bill along with three other bills are right now in committee and will come out on the floor this week. Charmain and I were talking earlier that before the Norwood Bill can be voted on, the other three have got to fail. The other three don't give us what we want as physicians. If you have the opportunity, I would assume that all of you have democratic congressmen, but if you know Chip Pickering, if you know Roger Wicker, drop them a note, have your patients drop them a note, have your friends drop them note and say sign the Norwood Bill..... because that is what we need and that is what gives the people of Mississippi the rights that they need. So if you can do that, please try to do that this week while it is hot and heavy on the floor. If Congress can pass the bipartisan bill, and it comes to caucus committee we will have a bigger stick in negotiating than we have ever had before and have a chance to give patients what they need.

"The last thing I want to talk about and then I will be glad to answer any questions is that Jim asked me to comment just briefly the loss of MPCN and the State Employees Insurance program. We bid on that this year as a number of you know. We lost it. Again, I feel that we gave a competitive bid. We were very honest in our bid. The things that we told people that we could do, we felt like we were able to do, but it just did not meet the RFP that they put out. Rest assured we are going to continue to be competitive in this, and keep an eye on where this is going. This does not preclude us from treating patients or seeing the patients that are state employees. I think that a number of you probably realize that the ..... process has to be done again, and a number of things have to be redone again. I can assure you that MPCN will be trying to work to get that state business.....

"I would like to close leaving you with one of my favorite statements. A saying from Winston Churchill when he said, 'A pessimist sees difficulty in every opportunity. An optimist sees opportunity in every difficulty.' I think that if we as physicians take those opportunities in those difficult situations then we can indeed be a better medical association and get the things that we want as physicians in this State and in this country. Thanks."

## Lee County Medical Alliance is Striving for Good Health



*Ms. Good-For-You, Tera Thorderson, talks to campers about good health habits*



*Thomas Street Elementary School with Puppets*

As the spouses of doctors, the members of the Lee County Medical Alliance are doing their share in making our county a healthier place to live. The Alliance tries to reach everyone in the county to spread the message about good health habits and personal safety. One of the Alliance's most rewarding projects is the "Camp Good For You" puppet show.

In 1985, the Lee County Medical Auxiliary started the puppet show project as a means to promote positive messages about good eating habits, proper diet, exercise and good sleep practices. The puppet show was originally entitled "You Can't Fool Mother Nature". The script was written by Susan McDonald and the puppets were designed by Judy Taylor. Ms. Taylor was a member of the National and Mississippi Puppeteers Associations. The puppet characters looked similar to the Jim Henson Muppets. The characters included four puppets; Candy, a little girl who was not doing well in school, Chips, a little boy who was chronically tired, Tasha Twinkle, a ballerina who serves as a roll model for Candy and Hunk Bunker, an athlete full of enthusiasm and good health. These puppets were joined by alliance members playing the parts

of Mother Nature, Sunbeam, who was Mother Nature's sidekick and keeper of the book of rules, and Blooper, a sickly person who was a classic health rule breaker.

The puppet show was used as a Doctors' Day tribute. Through the efforts of the Alliance, every kindergarten aged child in the Lee County public school system was entertained and enlightened about good health habits. The puppet show schedule usually ran about a week with different Alliance members taking the parts of the puppets.

In 1992 the puppet show was updated and renamed "Camp Good For You". The puppets faces stayed the same, but their clothes were updated. The characters names were changed to Penny, Betty Lou, Will and Jim. The part of Ms. Good-For-You, the camp director, was played by an Alliance member. The script had the same basic educational concepts. The Alliance did feel the need to expand the information to include fire safety with the "Stop, Drop and Roll" slogan and not talking to strangers. It also stresses the importance of telling an adult when things go wrong, even if it is something the child is not supposed to be doing. The ending of the puppet show now includes a song sung by the puppets that reminds the



*After the show, Ms. Good-For-You Tera Thorderson and Puppeteer Susan Rish showing the children the puppets.*



*Ms. Good-For-You kisses the burned hand of Jim*

testicular cancer, date rape, sexually transmitted diseases and organ donation. In April, 2000 the Alliance will be sponsoring a "Kick Butts Day" which is part of an anti-smoking program that will be presented to the fifth and sixth graders. In May, 2000 the Alliance will concentrate on teen pregnancy and abstinence.

Being part of the Lee County Medical Alliance is hard but rewarding work! It is through the efforts of many dedicated physicians' spouses that all this wealth of information is shared.

— **Susan W. Rish,**  
**President, Lee County Medical Alliance**

children of all the basic ideas about good healthy living.

The puppet show is one of the favorite programs of the Alliance. It gives us all a chance to become a child again. The best part of the puppet show is after the performance the Alliance puppeteers come out from behind the stage and let the children see the puppets and have an opportunity to touch and interact with them. The Alliance provides a coloring book for each child which reinforces the safety guidelines. The puppet show is now performed for all public, county and private schools. The show's schedule has also been changed from March to November. The Alliance felt the puppet show would have more impact if it was performed in November as it is National Safety Month.

The goal of the Lee County Medical Alliance is to provide everyone in the county an opportunity to hear about safety and good health habits. The Alliance is involved in every aspect of educating Lee Countians from infancy to adulthood. On National SAVE Day, October 13, 1999, the Alliance held a vigil on the courthouse lawn to remind everyone to stop the violence everywhere. Mayor Glenn McCullough signed a proclamation against violence, and a delegate from the police department and SAVE Shelter spoke.

The Alliance is involved in programs educating teenagers at the high school about the dangers of breast and

## Other MSMA Alliance Activities

*Chuck Donald speaks with the ladies of Louisville on "What Happens to the Family When Your Mom is Fighting Breast Cancer". BATTLE (Breast cancer Awareness to Teach Ladies Early Detection) is a statewide project of the Alliance. This luncheon was partnered with East Mississippi Medical Alliance, MSMA and Alliance, Mississippi Extension Service, and the Mississippi Academy of Family Physicians.*



*Members of South Mississippi-Laurel County Alliance examine wrapping paper which is a major fund raising project for the American Medical Foundation.*



*Mary Helen Schaeffer, President MSMA Alliance, and Hope Grayson, AMA Alliance representative, discuss membership plans with Rusty Roden, President Elect, Lee County Medical Alliance.*



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Identify yourself as a participant in the 2000 National Leadership Development Conference. Register before the February 25, 2000, cut-off date.

**AMA/Glaxo Wellcome Emerging Leaders Development Program**

This day-long skill-building experience on March 25, 2000, is by invitation only and is limited to 50 physicians. The program aims to help physicians succeed in the legislative/regulatory, organized medicine, and managed care arenas. An application, which must be postmarked by December 17, 1999, can be found on the AMA Web site at [www.ama-assn.org](http://www.ama-assn.org). Participation includes complimentary registration for the NLDC and CME credit.

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## Information and Quality Healthcare Pneumonia Project

The pneumonia project undertaken by I.Q.H. in the Fifth Scope of Work contract is continuing in the Sixth Scope of Work which began in August. The purpose of the project is to improve the care of patients and identify improvement areas in the care of patients during their hospitalization. The project was undertaken because several studies using national clinical guidelines for pneumonia management indicated that the lengths of stay, complications, readmissions, and mortality could all be decreased by adherence to the guidelines.

Remeasurement results in Fifth Scope efforts, which included 35 hospitals participating, reflected that these hospitals had been successful in improving the care of Medicare patients with pneumonia.

The Fifth Scope quality indicators included: antibiotic administration; blood culture collected within 24 hours of arrival; and assessment of blood oxygen saturation within 24 hours of arrival.

**Remeasurement on these indicators showed improvements in the following:**

- The median time to initial antibiotic administration decreased from 6.24 hours to 5 hours;
- Blood culture within 24 hours of arrival increased from 42 percent to 56 percent;
- Blood oxygen assessment within 24 hours of arrival increased from 73 percent to 84 percent.

New quality indicators for the Sixth Scope include:

- Timing of initial antibiotic administration;
- Blood cultures collected before antibiotics administered;

- Initial antibiotic consistent with current recommendations;
- Inpatients with pneumonia screened for and given the influenza and pneumococcal immunizations where needed.

These last three quality indicators are the most recent additions to the project.

The emergence of antibiotic resistant strains of *Streptococcus Pneumoniae*, combined with the need for prompt initiation of treatment, makes appropriate empiric antibiotic selection important. **The current IDSA and ATS guidelines recommend:**

**For patients who are being admitted to the floor:**

- Beta-lactam monotherapy (IV);
- Beta-lactam (IV) + Macrolide (IV or PO);
- Quinolone monotherapy (IV or PO).

**For patients admitted to ICU:**

- Beta-lactam (IV) + Macrolide (IV);
- Beta-lactam (IV) + Quinolone (IV).

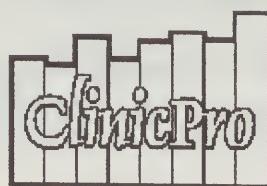
**If documented Beta-lactam allergy:**

- Quinolone (IV) + Clindamycin (IV);
- Quinolone (IV) + Vancomycin (IV).

Assessment of the immunization status for influenza and pneumococcal vaccines is a high priority as these patients are vulnerable for recurrent infections.

*Questions concerning this project can be directed to Dr. Alton Cobb as the clinical coordinator, and Donna Foster, R. N., B. S. N., project manager.*

The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content does not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.



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**Online CME** allows you to register and obtain continuing medical education credits via the internet.

The screenshot shows the homepage of the MSMA Online website. At the top, there's a navigation bar with links like 'HOME', 'MEMBERSHIP', 'PRACTICE', 'EDUCATION', 'MEMBER SERVICES', 'PUBLICATIONS', 'ADVERTISE', and 'CONTACT'. Below the navigation is a large banner with the text 'This is the grand Opening of the MSMA website. Please take the time to look.' and 'The Mississippi State Medical Association (MSMA) is a physician organization serving as an advocate for its members, their patients and the public health. The association promotes ethical, educational and clinical standards for the medical profession and the enactment of just medical laws.' There are also links for 'MSMA News', 'MSMA Foundation', 'MSMA Foundation', 'MSMA Foundation', and 'MSMA Foundation'.

### Online Directory

allows you to directly connect with other members.

### Online Links

allows you to connect with related organizations.

### Online Membership

allows you to process your application or renewal and payment via the internet.

### Online Messageboard

allows you to post your message, communicate with other members, MSMA officers and staff.

### Online Physician Locator

allows you to locate other members by specialty and by location.

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